Uniform Medical Plan

Your health. Your plan. Your choice.

Billing & Administrative Manual

for Professional Providers

www.ump.hca.wa.gov

Washington State Health Care Authority

Public Employees Benefits Board

HCA 54-689

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Visit the UMP Web site at www.ump.hca.wa.gov to download the latest versions of this manual, and all other UMP publications mentioned in this document.

Washington State Health Care Authority

Public Employees Benefits Board

HCA 54-689 (3/06)

Uniform Medical Plan
Your health. Your plan. Your choice.
Washington State Health Care Authority
PO Box 91118■Seattle, WA 98111-9218
206-521-2000■Fax 206-521-2001■TTY/TDD 360-923-2701
www.ump.hca.wa.gov

Dear Provider:

Thank you for participating in Uniform Medical Plan (UMP) provider network(s). Enclosed are billing instructions that we hope you will find helpful. UMP is a self-insured, preferred provider medical plan designed by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA). Our motto—"*Your health.Your plan.Your choice.*"—reflects UMP's philosophy, emphasizing freedom of choice paired with enrollee responsibility for care management.

UMP offers one of the largest published provider networks in the state of Washington, as well as a nationwide retail pharmacy network with a mail-order option.

Since UMP's benefit structure requires cost-sharing on the enrollee's part, this works to promote the responsible use of health care resources. UMP encourages providers and enrollees to work together to achieve optimal health outcomes at an acceptable cost. In today's environment, many health care consumers covered by insurance are not aware of the true cost of health care services; UMP's cost-sharing structure tends to enhance awareness.

In addition to our statewide Preferred Provider Organization (PPO) network and coverage, UMP also administers UMP Neighborhood for residents of King, Pierce, and Snohomish counties. In UMP Neighborhood, patients receive most health care services through a "care system" (a more limited choice of network providers) that they select when they enroll.

Please take the time to review this *UMP Billing & Administrative Manual*, as well as our current *Certificates of Coverage* (COCs) and *Preferred Drug List* for UMP PPO and UMP Neighborhood. Information pertaining to UMP Neighborhood is included in this manual in Appendices A-4 to A-6.

You may also access these documents, fee schedules, and other information by visiting our Web site at **www.ump.hca.wa.gov**. In addition, the Web site includes our network provider directories for UMP and UMP Neighborhood. UMP also gives providers online access to secure information (such as enrollee eligibility and payments toward the annual deductible, and claims status) through OneHealthPort. For more information, go to **www.onehealthport.com** or click on the links from our Web site.

If you have any questions regarding UMP policies and procedures, fee schedule information, or if you need additional training, please do not hesitate to call us toll-free at 1-800-292-8092, or locally at 206-521-2023. To confirm patient eligibility, call toll-free 1-800-335-1062; you will need to have the subscriber identification number to access eligibility information. When prompted by the automated system, you should choose the number which selects "PEBB subscriber information."

We are pleased to have you as a network provider, and look forward to working with you to provide quality care and customer service to all of our enrollees.

Sincerely,

Janet Peterson
Executive Director

Mary Kay O'Neill, M.D.
Associate Medical Director

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Section 7: Payment Rules (cont.)

Section 8: Provider Inquiries, Complaints, Reconsideration Procedures, and Dispute Resolutions

Appendices

To obtain this booklet in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Section 1

Quick Reference Notes

1.1

How to Reach Us

Uniform Medical Plan Web site
www.ump.hca.wa.gov

1.1.1 Addresses and Phone Numbers

Uniform Medical Plan Customer and Provider Services

- Benefits information
- Claims status and information
- Enrollee eligibility information*
- General billing questions
- Interactive Voice Response (IVR) system
- Medical review
- Notification/preauthorization
- Verify provider's network status

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

Provider Services
Toll-free 1-800-464-0967
Local..... 425-686-1246
Fax 425-670-3199

Active Enrollees
Toll-free 1-800-762-6004

Retired Enrollees
Toll-free 1-800-352-3968

Case Management Services
Toll-free 1-888-759-4855

Automated Enrollee Eligibility Information
Toll-free 1-800-335-1062 (Have subscriber I.D. number available, and select #2 for "PEBB subscriber information.")

Electronic Claims Submission

The following clearinghouses frequently submit claims electronically to UMP.

Electronic Network Systems
www.enshealth.com
Toll-free 1-800-341-6141

Emdeon Business Services™
(formerly known as WebMD)
www.emdeon.com
Toll-free 1-877-469-3263

MedAvant Healthcare Solutions
(formerly known as ProxyMed)
www.proxymed.com
Toll-free 1-800-586-6870

The SSI Group
www.thessigroup.com
Toll-free 1-800-880-3032

Claims with attachments may also be submitted electronically through Office Ally. You can register for this free service on the OneHealthPort Web site at **www.onehealthport.com**. If you have trouble registering, call Office Ally customer support at 949-464-9129.

Provider Credentialing and Contracting Issues

- Billing manuals and payment policies
- Change of provider status
- Fee schedules
- Network provider applications and contract information
- New provider enrollment
- Policies and procedures
- *Provider Bulletin* feedback

Uniform Medical Plan
P.O. Box 91118
Seattle, WA 98111-9218

Toll-free 1-800-292-8092
Local..... 206-521-2023
Fax 206-521-2001

Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Physicians Network

- Network provider applications and contract information
- Billing procedures
- Fee schedule and payment policy information

American WholeHealth Networks
(Axia Health Management; formerly Alternáre)
Toll-free 1-800-274-7526
1-800-500-0997

Prescription Drugs (retail and mail-order)

- Benefits information
- Claims information
- Cost share information
- Eligibility verification
- Preferred drug list information
- Prior authorization requests
- Network pharmacy information (location and network verification)

Express Scripts, Inc.
Toll-free 1-800-763-5502

To fax prescriptions (providers)
Toll-free 1-800-396-2171
Must be faxed on provider's letterhead (see Section 7.17).

To call in prescriptions (providers)
Toll-free 1-800-763-5502

Preauthorization of prescription drugs
Toll-free 1-800-417-8164
Fax 1-877-697-7192

Appeals and Correspondence
Toll-free 1-800-417-8164
Fax 1-877-852-4070

Express Scripts, Inc.
Attn: Pharmacy Appeals: WA5
Mail Route BLO390
6625 West 78th Street
Bloomington, MN 55439

Vendor for Specialty Prescription Drugs
CuraScript
To call in prescriptions for specialty drugs
Toll-free 1-866-413-4135

Tobacco Cessation Services

Free & Clear
Toll-free 1-800-292-2336

1.1.2 Web Site Information

Uniform Medical Plan
www.ump.hca.wa.gov
- *Billing & Administrative* manuals
- *Certificates of Coverage* (benefits books)
- *Network Provider Directory*
- *Preferred Drug List*
- *Professional Provider Fee Schedule*
- *Ambulatory Surgery Center Fee Schedule*
- *Anesthesia Fee Schedule*
- *Chiropractor Fee Schedule*
- *Prosthetic and Orthotic Fee Schedule, Including Ostomy and Urological Supplies*
- All-Patient Diagnostic Related Group Weights used for Hospital Reimbursement
- Other important UMP information

OneHealthPort
www.onehealthport.com
- Register with OneHealthPort for access to secure online services and e-mail to manage your UMP business

U.S. Preventive Services Task Force Guidelines
www.ahcpr.gov/clinic/gcpspu.htm
- Preventive care guidelines

Centers for Disease Control's National Immunization Program
www.cdc.gov/nip/publications/ACIP-list.htm

Express Scripts, Inc.

www.express-scripts.com

- General prescription drug information

Note: See the UMP Web site **www.ump.hca.wa.gov** for UMP-specific information on prescription drugs.

Free & Clear

www.freeclear.com

- Tobacco cessation program information

American WholeHealth Networks

(Axia Health Management; formerly Alternáre)

www.wholehealthpro.com

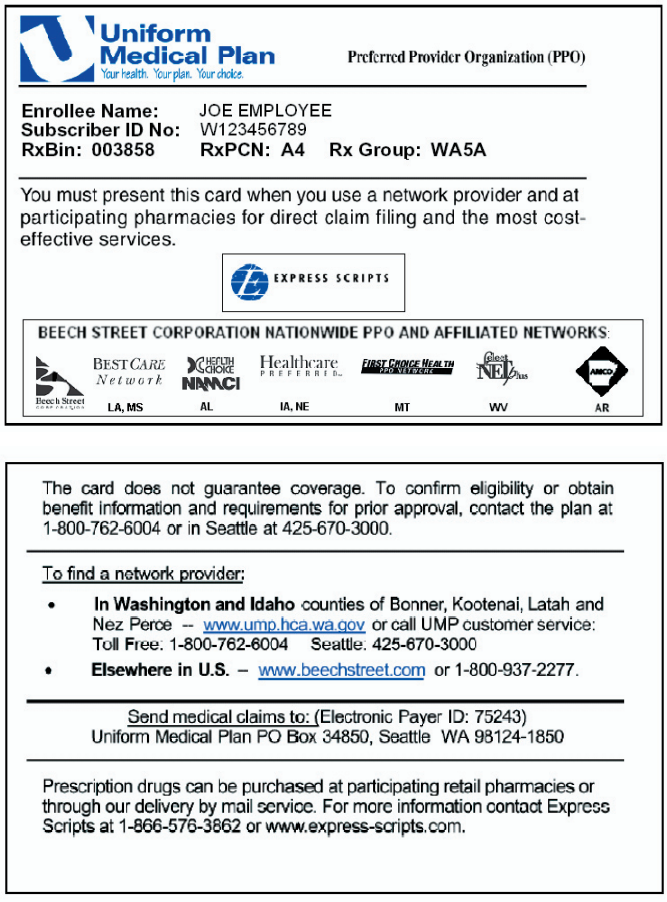
- Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Physicians—network provider resources information

1.2

Sample Uniform Medical Plan Identification Card

This is the identification card that confirms UMP Preferred Provider Organization (UMP PPO) enrollment. Each UMP PPO enrollee is issued an identification card with a unique 9-digit number prefixed by a "W." Please note that UMP no longer uses social security numbers for eligibility and claim records. Please use the "W" number on all claims and inquiries.

A sample of the UMP Neighborhood identification card is included in Appendix A-4, Section 1.2.



1.3

Claims Submission Information

Paper claims (CMS-1500) should be mailed within 60 days of service (but not beyond 365 days) to the UMP claims office at the following address:

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

Claims with missing, inaccurate, or invalid information will be denied or sent back for clarification and resubmission.

Electronic claims submission provides efficiency to your business.

If you are already connected to one of the following clearinghouses that frequently transmits claims electronically, continue to submit your UMP claims to payer I.D. number 75243.

Electronic Network System
www.enshealth.com
Toll-free 1-800-341-6141

Emdeon Business Services™
(formerly known as WebMD)
www.emdeon.com
Toll-free 1-877-469-3263

MedAvant Healthcare Solutions
(formerly known as ProxyMed)
www.proxymed.com
Toll-free 1-800-586-6870

The SSI Group
www.thessigroup.com
Toll-free 1-800-880-3032

If you are currently submitting paper claims, we encourage you to contact a clearinghouse for information on submitting claims electronically.

Providers may also submit claims electronically with attachments to UMP using Office Ally. This Internet-based tool allows providers either to directly enter claims through a Web browser or upload a batch file from existing claims data systems. Office Ally checks for correct dates, CPT® codes, and ICD-9-CM codes before sending your claims to UMP. You'll receive e-mail confirmation and feedback on incomplete claims within 24 hours. Your practice will be paid faster and the service is ***free***!

Examples of attachments UMP can receive include medical reports, X-rays, copy of an enrollee's I.D. card, itemized bills, and other carriers' explanations of benefits.

You can register for this free service by clicking on "Office Ally" on the OneHealthPort Web site at **www.onehealthport.com**. Use UMP's payer ID number 75243 when submitting claims. If you have trouble registering, call Office Ally customer support at 949-464-9129.

1.4

Provider Network Participation

UMP PPO benefits are structured to encourage enrollees to use the services of network providers. As a financial incentive and to promote quality of care, the plan provides for considerable cost sharing for enrollees who do not use network providers.

As a UMP network provider, you are expected to refer patients to other network providers. Contact UMP at 1-800-464-0967 or 425-686-1246 when you need to confirm a provider's participation in the network. If the patient is a UMP Neighborhood enrollee, see Appendix A-4 for referral information and pass requirements.

UMP recognizes that most providers have established referral patterns and we do not wish to disrupt them. If the providers you routinely refer to are not UMP PPO network providers, but are interested in joining the UMP PPO network, please refer them to the Provider Services Division by calling toll-free 1-800-292-8092, or locally 206-521-2023. Non-network providers will also be solicited at your request. Please note, however, that all providers must meet UMP credentialing criteria prior to receiving network provider status.

UMP PPO is not a closed network. However, due to administrative resource constraints, we have established priorities for adding new providers. UMP is focusing on the credentialing of applicants in specialties and geographic areas where additions to the UMP PPO network are critical for enrollee access to care. When a request or application is received from a provider for a non-priority area, the provider is notified that we will not be processing the application at this time. Applicant information is retained for future consideration. UMP routinely analyzes statewide network adequacy in relation to the location and needs of our enrollees.

1.5

UMP Web Site and Online Services

There is a dedicated section for providers on the UMP Web site at **www.ump.hca.wa.gov** where up-to-date information can be easily obtained at any time. This includes the most current UMP *Certificates of Coverage* (benefit books), billing manuals, fee schedules, *Preferred Drug List*, and the online provider directory.

Along with other health care organizations in the community, UMP uses a single portal (through OneHealthPort) for provider access to secure information. This secure provider portal can be accessed through the UMP Web site. This security measure allows UMP to link to providers' offices with important information needed to manage their UMP business such as:

- Benefits information on UMP PPO and UMP Neighborhood;
- Eligibility effective dates and basic demographics for UMP enrollees;
- Coordination of benefits information to determine if another insurance carrier, including Medicare, is primary for a patient;
- Deductible status as to whether the patient has met his/her deductible;
- Detailed claims information including message codes to let you know if a UMP PPO or UMP Neighborhood claim is in process, if more information is needed, or if a claim has been finalized;
- References and forms for billing, Neighborhood Pass (applies only to UMP Neighborhood), I.D. cards, and filing claims electronically;
- Search capability for finding information in UMP's provider directory and *Preferred Drug List*;
- Secure e-mail to exchange messages containing confidential information with UMP's claims administrator.

To use the secure provider portal, click on "Online Services" or "OneHealthPort" in the provider section of the UMP Web site at **www.ump.hca.wa.gov**. You will need to choose an administrator from your organization to manage the organization's account and complete the OneHealthPort registration process, which you can do online. After registration, the administrator will have access to the UMP secure site and information. The designated administrator can then give appropriate staff in the organization their OneHealthPort credentials to access UMP information.

1.6

Administrative Simplification Initiatives

Administrative simplification—reducing the hassle factor, streamlining policies and procedures, and decreasing nonproductive work—continues to be a key focus of UMP. UMP has established an internal review process to identify and resolve burdensome administrative policies and procedures. UMP continues to work with other state agencies to develop, implement, and maintain uniform payment methodologies and policies that are consistent with industry standards.

UMP also participates with the Washington Healthcare Forum in their administrative simplification initiatives. The Forum is a coalition of health plans, physicians, hospitals, and purchasers working together to standardize processes among payers. UMP has adopted many of the Forum's policies and guidelines related to claims processing, and referral and prospective reviews. These standard policies and guidelines are posted on the Forum's Web site at **wahealthcareforum.org**.

Section 2

Program Outline

Questions regarding fee schedule development and administration? Call 206-521-2023 or 1-800-292-8092.

2.1

Overview of the Uniform Medical Plan Preferred Provider Organization (UMP PPO)

The Uniform Medical Plan Preferred Provider Organization (UMP PPO) is a self-insured, preferred provider plan for public employees and retirees. It is sponsored by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA).

UMP PPO coverage includes medical, surgical, and obstetric services; chemical dependency and mental health treatment; organ transplants; and prescription drugs. All enrollees have benefits for routine preventive care, vision and hearing examinations, tobacco cessation services, and diabetic education.

See the UMP *Certificates of Coverage* (available on the UMP Web site at **www.ump.hca.wa.gov** or by calling 1-800-464-0967) for deductible, coinsurance, and copayment requirements, as well as for a complete description of plan benefits and scope of coverage.

2.2

Uniform Medical Plan Professional Provider Fee Schedule

2.2.1 RBRVS Overview

The Resource Based Relative Value Scale (RBRVS) methodology is used by the three primary purchasers of health care in Washington State:

- The **Health Care Authority (HCA)**—The state agency that administers UMP for public employees and retirees.
- The **Department of Labor and Industries (L&I)**—The state agency that administers the state's workers' compensation program (State Fund Industrial Program only).
- The **Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA)**—The state agency that administers the state's Medicaid program.

These three agencies form a group known as the Reimbursement Steering Committee (RSC) to develop, maintain, and update the fee schedules and payment policies. Under the RBRVS approach, the agencies have a common set of relative value units. While the basis of the fee schedules is the same for the state agencies, payment levels differ because agency-specific conversion factors are used. Advice is provided by the State Agency Technical Advisory Group (TAG), which represents most major provider specialties in the state. The technical elements as well as the process for developing and maintaining the fee schedule are discussed below.

2.2.2 RBRVS Technical Elements

The UMP statewide fee schedule is based on relative value units (RVUs) and a conversion factor. The RVUs are geographically adjusted for Washington State. The primary sources for the RVUs and geographic adjustment factors are the Medicare Physician Fee Schedule Data Base and Federal Register publications. The RVUs from these sources are established by the Centers for Medicare & Medicaid Services (CMS), based on the resources required to perform each service, such as the work, practice expense, and liability insurance.

Fee schedule allowances are generally updated on an annual

basis as new RVUs become available. Fee schedule allowances are available on the UMP Web site at **www.ump.hca.wa.gov** or upon request by calling the numbers at the beginning of this section.

2.2.3 Procedure Codes and Modifiers

The state agencies identified in 2.2.1 have adopted common coding rules to use and follow the most recent updated version of Physician's Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) level II procedure codes and modifiers to the extent possible.

CPT® procedure codes are revised and published each year by the American Medical Association (AMA). The annual updates are generally published in November, and become effective on January 1 of the following year. Additional updates to CPT® category I, II, and III codes are also electronically released on the AMA Web site for use as of January 1 and July 1 in a given CPT® cycle.

Please note: CPT® category II codes are valid for tracking purposes but they are not recognized for payment purposes.

HCPCS level II procedure codes are maintained by the Centers for Medicare & Medicaid Services (CMS) and are also published annually. Periodically, additional new HCPCS codes are added by CMS during the year, which are released via their program transmittals and/or the Web site. HCPCS level II procedure codes are published by the U.S. Government Printing Office and by a number of commercial publishers.

UMP does not allow payment for CPT® codes or HCPCS level II procedure codes after new publications identify them as being deleted and invalid.

Due to its licensing agreement with the American Medical Association, the UMP *Billing & Administrative Manual* contains abbreviated definitions of procedure codes. For billing purposes, please refer to the most current edition of the CPT® and HCPCS books for complete descriptions of the procedure codes.

The use of modifiers is explained in more detail in Sections 7.1.5, 7.2.5, and 7.3.3 of this manual.

2.2.4 Included Services

Care provided by physicians and other practitioners related to the following services will be reimbursed under the UMP fee schedule based on the RBRVS methodology:

- Chemical dependency
- Diagnostic studies
- Family planning
- Hearing care
- Hospital outpatient and emergency care
- Laboratory services
- Medicine, including allergy, immunology, and dermatology
- Mental health care
- Obstetric and newborn care
- Office visits and institutional visits
- Physical, occupational, and speech therapy
- Preventive care
- Radiation and chemotherapy
- Spinal and extremity manipulations
- Surgery
- Vision care

Please refer to the UMP *Certificates of Coverage* for details regarding scope of coverage of these benefits.

2.2.5 Excluded Services

Certain groups of services, although covered by UMP, are excluded from RBRVS pricing. Excluded services include:

- Ambulance and transportation services
- Dental services
- Durable medical equipment
- Inpatient and outpatient facility fees
- Pharmacy services
- Prosthetics/orthotics (see the UMP *Certificates of Coverage* for limited orthotic coverage)

2.2.6 Payment

The Health Care Authority uses the UMP fee schedule referenced throughout this document as a schedule of UMP maximum allowances for network and non-network professional providers in Washington State. The allowed charge is the lesser of the provider's provider's billed charge or the UMP fee schedule amount.

Please note: The UMP fee schedule referenced throughout this document is not used for payment of

services provided by naturopathic physicians, massage therapists, and licensed acupuncturists. Covered services by these provider types are reimbursed according to the American WholeHealth Networks fee schedule allowances. Also, the UMP fee schedule generally applies only for services in Washington State and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce.

Section 3

Billing Instructions

Questions regarding billing procedures? Call 206-521-2023 or 1-800-292-8092.

3.1

Instructions for Completing CMS–1500 Claim Forms

All professional claims must be submitted on CMS–1500 claim forms. The following instructions specify how to complete each required field on the CMS–1500 for claim payment. Field numbers and names shown in bold type signify very important information. If this information is missing or inaccurate, claims processing may be delayed or denied. A sample CMS–1500 form (Exhibit 3-1) follows these instructions.

No.	Field Name	Instructions
1	Coverage Type	Check the box labeled Group Health Plan. Check other types of coverage as applicable.
1a	**Insured's I.D. Number**	**Enter the insured's UMP identification number.**
2	**Patient's Name**	**Enter the patient's full name (last name, first name, middle initial).**
3	**Patient's Birth Date**	**Enter the patient's date of birth in MM/DD/YYYY format. For example, July 8, 1950, would be entered as 07/08/1950.**
	Sex	**Check the appropriate box: M=male, F=female**
4	**Insured's Name**	**Enter the name of the insured, except when the insured and the patient are the same (then the word "Same" may be entered).**
5	**Patient's Address**	**Enter the patient's permanent mailing address and telephone number. On the first line, enter the street address; the second line is for the city and state; the third line is for the ZIP Code and phone number.**
6	**Patient Relationship**	**Check the appropriate box: Self, Spouse, Child, or Other. If Other, describe your relationship to the insured person.**
7	**Insured's Address**	**Enter the insured's address and telephone number, except when the address is the same as the patient's (then the word "Same" may be entered). Complete this field only when fields 4, 9, or 11 are completed.**
8	**Patient Status**	**Check all boxes that apply: Single, Married, or Other; and Employed, Full-Time Student, Part-Time Student.**
9	**Other Insured's Name**	**If the patient is covered by other insurance, enter the last name, first name, and middle initial of the other plan's policyholder if it is different from that shown in field 2. Otherwise, enter the word "Same."**
9a	**Other Insured's Policy or Group Number**	**If the patient is covered by other insurance, enter the policy or group number of the plan.**
9b	**Other Insured's Date of Birth**	**If the patient is covered by other insurance, enter the policyholder's date of birth in MM/DD/YYYY format. For example, July 8, 1950, would be entered as 07/08/1950.**
	Sex	**Check the appropriate box: M=male, F=female**

No.	Field Name	Instructions
9c	Employer's Name or School Name	If the patient is covered by other insurance, enter the name of the policyholder's employer or school, if applicable.
9d	**Insurance Plan Name or Program Name**	**If the patient is covered by other insurance, enter the other insured's plan name or the program name (i.e., the patient's health maintenance organization).**
10	**Accident Determination**	**If the patient's condition is accident-related, check the appropriate box: Employment, Auto Accident, or Other Accident.**
11	**Insured's Policy Group or FECA Number**	**Enter the policy number of the insured's Uniform Medical Plan: 029.**
11a	**Insured's Date of Birth**	**Enter the insured's date of birth and sex, if different from item 3.**
11b	**Employer's Name or School Name**	**Enter the employer name or school name for the insured.**
11c	**Insurance Plan or Program Name**	**Enter the plan name: Uniform Medical Plan.**
11d	**Other Health Benefit Plan**	**Check "Yes" or "No" to indicate whether there is another primary health benefit plan. For example, the patient may be covered under insurance held by a spouse, parent, or some other person. If there is information in fields 9 through 9d, "Yes" must be checked. If "No" is checked, then these items would be blank. If "Yes" is checked and fields 9 through 9d are blank, claims processing will be delayed.**
12	**Patient's or Authorized Person's Signature**	**Have the patient or his/her authorized representative sign and date this block unless the signature is on file.**
13	Insured's or Authorized Person's Signature	Optional, may be left blank.
14	**Date of Current Illness, Injury, or Pregnancy**	**Enter date of onset of current illness, injury, or pregnancy.**
15	Date of Same or Similar Illness	Leave blank.
16	**Dates Patient Unable to Work in Current Occupation**	**Enter date if patient is unable to work. An entry in this field could indicate employment-related insurance coverage. If this item is applicable, field 10 (Accident Determination) may also require completion.**
17	**Name of Referring Provider or Other Source**	**If the services are the result of a referral, then enter the name of the referring physician.** ***Note:*** *The prescribing provider's complete name (including credentials such as MD, DO, DPM, DC, ND, ARNP) must be indicated in this field for physical, occupational, speech, and massage therapy.*
17a	I.D. Number of Referring Physician	Optional, may be left blank.
18	Hospitalization Dates Related to Current Services	Optional, may be left blank.
19	Reserved for Local Use	Optional, may be left blank.
20	Outside Lab	Complete this item when billing for diagnostic tests subject to purchase limitations. Enter the purchase price under charges if the "Yes" block is checked. A "Yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "No" check indicates that no purchased tests are included on the claim. When "Yes" is annotated, field 32 must be completed.

No.	Field Name	Instructions
21	**Diagnosis or Nature of Illness or Injury**	**Enter up to four ICD–9–CM diagnosis codes in priority order (primary, secondary condition). Report the highest level of specificity. Enter the appropriate diagnosis code for screening mammography.**
22	Medicaid Resubmission	Leave blank.
23	Prior Authorization Number	Optional, may be left blank.
24a	**Dates of Service**	**Enter the month, day, and year for each procedure, service, or supply. If "from" and "to" dates are shown here for a series of identical services, the number should appear in field 24g.**

24b Place of Service (POS)

Please note: This field is required or the claim will be denied. Place of service code "11" (office) may not be used for services furnished in hospital outpatient departments or hospital-based entities (i.e., any clinic that meets Medicare's criteria for "provider-based" designation). Use place of service code "22" (outpatient hospital) or, if applicable, "23" (emergency room-hospital) in this circumstance.

This place of service code list was accurate at time of publication. Refer to the CMS Web site at **http://new.cms.hhs.gov/PlaceofServiceCodes/** for the most current list.

Enter the code which describes the place of service:

01	**Pharmacy**
03	**School**
04	**Homeless Shelter**
05	**Indian Health Service Free-Standing Facility**
06	**Indian Health Service Provider-Based Facility**
07	**Tribal 638 Free-Standing Facility**
08	**Tribal 638 Provider-Based Facility**
11	**Office**
12	**Home**
13	**Assisted Living Facility**
14	**Group Home**
15	**Mobile Unit**
20	**Urgent Care Facility**
21	**Inpatient Hospital**
22	**Outpatient Hospital**
23	**Emergency Room—Hospital**
24	**Ambulatory Surgical Center**
25	**Birthing Center**
26	**Military Treatment Facility**
31	**Skilled Nursing Facility**
32	**Nursing Facility**
33	**Custodial Care Facility**
34	**Hospice**
41	**Ambulance (Land)**
42	**Ambulance (Air or Water)**
49	**Independent Clinic**

No.	Field Name	Instructions
		50 Federally Qualified Health Center **51 Inpatient Psychiatric Facility** **52 Psychiatric Facility Partial Hospitalization** **53 Community Mental Health Center** **54 Intermediate Care Facility/Mentally Retarded** **55 Residential Substance Abuse Treatment Facility** **56 Psychiatric Residential Treatment Center** **57 Non-Residential Substance Abuse Treatment Facility** **60 Mass Immunization Center** **61 Comprehensive Inpatient Rehabilitation Facility** **62 Comprehensive Outpatient Rehabilitation Facility** **65 End Stage Renal Disease Treatment Facility** **71 State or Local Public Health Clinic** **72 Rural Health Clinic** **81 Independent Laboratory** **99 Other Unlisted Facility**
24c	Type of Service	Leave blank.
24d	**Procedures, Services, or Supplies**	**Enter the appropriate procedure code and modifier, if applicable. Only current CPT® and HCPCS level II procedure codes (with appropriate modifiers, where required) will be accepted for payment. For each procedure, show the corresponding diagnostic code in field 24e.**
24e	**Diagnosis Code**	**Enter the diagnostic code reference as shown in field 21, to relate the date of service and the procedures performed to the appropriate diagnosis.**
24f	**Charges**	**Enter the billed amount.**
24g	**Days or Units**	**Show the days, units, or anesthesia minutes in this block. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.**
24h	EPSDT	Leave blank.
24i	EMG	Check this item to indicate that the service was rendered in a hospital emergency room. If this block is checked, then the place of service code in field 24b should match.
24j	COB	Leave blank.
24k	Reserved for Local Use	Optional, may be left blank.
25	**Federal Tax I.D. Number**	**Show the physician/supplier federal tax I.D. number (employer identification number) or social security number.**
26	Patient's Account Number	Enter the patient's account number assigned by the physician's/supplier's accounting system. This is an optional field to enhance patient identification by the physician or supplier.

No.	Field Name	Instructions
27	Accept Assignment?	Leave blank.
28	**Total Charge**	**Enter the total of the charges listed for all line items.**
29	**Amount Paid**	**Enter the amount received from a third party. If another insurer has processed a claim for these services, an Explanation of Benefits (EOB) must be attached to the claim.**
30	Balance Due	Enter the balance due (field 28 less field 29).
31	**Signature of Physician or Supplier**	**The provider must sign or signature stamp each claim for services rendered, and enter the date. Only signed claims will be accepted for payment.**
32	**Name and Address of Facility Where Services Were Rendered**	**Enter the name and address of the facility where the services were rendered.**
33	**Physician's/Supplier's Billing Name, Address, Etc.**	**Enter the billing provider's name, address, and phone number.**

Exhibit 3-1 Sample CMS-1500 Form

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

3.2

Claim Submission Procedures

Questions regarding claims submission? Call 425-686-1246 or 1-800-464-0967.

3.2.1 Claim Submission Process

Claims submitted on paper must be mailed to UMP at:

Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34850
Seattle, WA 98124-1850

Providers are required to use the CMS-1500 claim form. Incomplete claims will cause delay or denial of claims payment. Services submitted with invalid procedure, diagnoses, or place of service codes will be denied.

You are encouraged to submit claims electronically. See Section 1.3, Claims Submission Information, to find out more about this option.

3.2.2 Timely Submission of Claims

Claims for covered services provided to an enrollee should be submitted within 60 days of the date of service. UMP will not process claims submitted more than 12 months after the date of service. Under exceptional circumstances such as when UMP is secondary and the primary payer has not paid on a timely basis, this provision may be waived upon approval by UMP.

To request a waiver, send a written memorandum explaining the circumstances to:

Manager, Customer Service
Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34850
Seattle, WA 98124-1850

3.2.3 Process for Resubmission of Claims and Adjustments

Corrected Claims: Providers are encouraged to attach the cover sheet found in Appendix A-8 of this manual when submitting corrected claims to UMP. This standard cover sheet is also posted on UMP's Web site and the Washington Healthcare Forum's Web site.

To resubmit a claim that was previously returned or denied for correction or additional information, simply attach a copy of the letter or Detail of Remittance (DOR) notice from UMP with the information requested and send it back with your regular batch of claims.

To request a reconsideration of a previously processed claim, network providers should contact UMP by phone, or write:

Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34578
Seattle, WA 98124-1578
Toll-free 1-800-464-0967
Local..... 425-686-1246

If UMP agrees that the claim warrants adjustment, the provider may be required to submit the corrected claim with supporting documentation and reason that the claim should be adjusted. The request for review should be no more than 180 calendar days after receiving the notice of action on the original claim.

The decision related to whether or not an adjustment is appropriate will generally be made within 30 calendar days of receiving the request for review. You will receive notice of the decision in the form of a new DOR with additional payment or a letter from UMP. If the adjustment is denied, you may submit a request for further reconsideration (or "Level 2 request") through the process described in Section 8.1.3 of this manual.

Note: UMP expects providers to bill accurately for services rendered. Changing of procedure or diagnosis codes or modifying records for the sole purpose of gaining additional payment from UMP, and not to correct an error, may be fraudulent.

3.2.4 Enrollee Appeals Procedure for Denied Claims

If a UMP enrollee feels that a claim has been incorrectly processed or payment wrongly denied, it is the responsibility of the enrollee to contact UMP at 1-800-762-6004. If the problem is not resolved to

the satisfaction of the enrollee, he or she may appeal to:

Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34578
Seattle, WA 98124-1578

Details of this process can be found in the current *Certificates of Coverage*.

3.2.5 Audit and Right of Recovery Policy

UMP's right to audit, inspect, and duplicate records maintained on enrollees by network providers is discussed in the contract between HCA/UMP and the provider.

Providers should promptly notify UMP of any overpayments or underpayments. UMP's right to seek prompt refund from the provider for any duplicate, excess, or otherwise erroneous payments, or to deduct the amount overpaid from future payments and take such action as it may consider appropriate, is also discussed in the contract between HCA/UMP and the provider.

3.2.6 Patients' Rights to Confidentiality

It is the responsibility of the provider to keep audit, billing, payment, medical, and other patient-related information for UMP enrollees confidential, except as necessary for performance of the contract between the HCA/UMP and the provider, unless required by law to do otherwise. A copy of the *Notice of Privacy Practices* is located on the UMP Web site and a hard copy is available on request.

3.2.7 Coordination of Benefits (COB)

Please note that Mutual of Omaha electronically transmits Medicare claims information for Medicare-enrolled UMP enrollees directly to UMP. This includes Medicare claims processed by Noridian Administrative Services and other Medicare contractors. Therefore, it is generally not necessary for you or your patients to send UMP paper claims and copies of the Explanation of Medicare Benefits /Medicare Summary Notices. For all other claims where UMP is the secondary payer, a copy of the original CMS-1500 claim form along with a copy of the EOB and/or Detail of Remittance (DOR) provided by the primary payer must be submitted to UMP for secondary payment.

When UMP PPO is secondary to another group medical insurance plan, reimbursement for services is based on standard coordination of benefits. This means that, after the enrollee's annual deductible has been met, UMP PPO plus the enrollee's other coverage combined pay up to 100 percent of allowed charges (but not more than 100 percent). Usually, enrollees who have UMP PPO as their secondary coverage pay no enrollee cost-share on most claims unless the annual deductible has not been satisfied.

For other services, here's how it works when UMP PPO is not the primary payer:

- The primary payer pays a portion of the bill and sends the enrollee an Explanation of Benefits (EOB); the enrollee sends a copy of the bill and the EOB to UMP PPO;
- UMP PPO reviews the primary plan benefit calculation, and the primary plan payment;
- UMP PPO determines what the normal benefit would have been if UMP PPO had been the only payer;
- UMP PPO compares allowed charges and determines which is the highest allowed charge; and
- UMP PPO pays the difference between the highest allowed charge and the primary plan's payment, up to the normal UMP PPO benefit amount.

Here's an example to illustrate the process and terms above. This example assumes that the primary plan ordinarily pays 80% of allowed charges after a $500 deductible.

Provider's charge	**$1,200**	
Primary Plan Benefit Calculation		
Primary plan's allowed charge:	$1,000	
Primary plan deductible (enrollee pays):	$500	
Primary plan pays:	$400	(80% of $500 balance)
UMP PPO Benefit Calculation		
UMP allowed charge:	$900	
UMP PPO deductible (enrollee pays):	$200	
UMP PPO normal benefit:	$630	(90% of $700 balance)
Actual Payment by UMP PPO		
Highest allowed charge:	$1,000	(primary plan)
Primary plan's payment:	$400	
UMP PPO pays:	***$600***	

For an example of coordination of benefits for UMP Neighborhood enrollees, see Section 3 of Appendix A-4.

3.2.8 Explanation of Benefits (EOB)

When the claim is paid, the patient receives an Explanation of Benefits (EOB) that shows the original submitted charges, any noncovered charges, the patient's responsibility, and the amount paid by UMP. A sample of the EOB for UMP PPO can be found in Appendix A-1. A sample of the EOB for UMP Neighborhood can be found in Appendix A-5.

The patient's EOB will also indicate when portions of the submitted charge have not been covered because the amount charged exceeds the contracted allowance for the service. The patient is not responsible for these charges and may not be billed for them.

3.2.9 Electronic Funds Transfer

Electronic Funds Transfer (EFT) is available to network providers. Through this function, UMP payments for claims are deposited more quickly and automatically into your organization's bank account. If you are interested in receiving your payments from UMP through this process, please send UMP a secure e-mail through your UMP provider portal account (set up via **www.onehealthport.com**). Once connected to the portal, click on the Electronic Funds Transfer links and follow the easy instructions on how to send a secure e-mail. There is no charge for this service.

3.2.10 Detail of Remittance (DOR)

Providers will receive a Detail of Remittance (DOR) from UMP, which will indicate the amount of charges being reimbursed for each claim. A sample of the DOR for UMP PPO can be found in Appendix A-2. A sample of the DOR for UMP Neighborhood can be found in Appendix A-6. The DOR identifies the patient by name, identification number, and the claim number assigned by the claims administrator. Then, for each service line of the claim, the DOR lists the service date, the procedure code of the service, submitted charges, allowed amount, noncovered charges, message code(s), deductible/copay/coinsurance amounts (patient responsibility), network provider discounted amount, patient balance, and amount paid by UMP.

For quicker communications, providers may choose to receive DORs electronically from UMP through selected clearinghouses. Through this payment option, your organization doesn't have to wait for delivery of the paper DOR, which is mailed through the United States Postal Service. For more information, please contact UMP toll-free at 1-800-464-0967 or locally at 425-686-1246.

3.2.11 Service Rebundling Software/DOR Messages

The UMP claims system examines claims and detects coding errors in which a service has been separately billed when that service is clinically considered a part of another service. This type of coding error is called "unbundling." In this situation, separate reimbursement for the bundled service will not be allowed, as it is considered in the UMP payment issued for another reported service. In general, UMP claims processing system edits are consistent with the National Correct Coding Initiative (CCI) edits. A message indicating that the service has been bundled for payment will appear on the DOR and on the subscriber's EOB. The enrollee is not financially responsible for the separate charges for the "unbundled service."

Section 4

Provider Information

4.1

Provider Requirements

Uniform Medical Plan network providers agree to comply with the following requirements.

4.1.1 Credentialing

Call 206-521-2023 or 1-800-292-8092

- Maintain applicable licensure, registration, and/or certification.
- Maintain professional liability insurance coverage with limits of liability as determined by HCA/UMP.
- Meet all other credentialing requirements documented in your *Network Provider Agreement* as determined by HCA/UMP.
- Accept UMP fee schedules and follow UMP policies and procedures.

4.1.2 Billing

Call 425-686-1246 or 1-800-464-0967

- Bill UMP no more than your usual and customary fee.
- Submit claims on CMS-1500 claim forms within 60 days after the covered services are rendered. In no instance can a claim be submitted later than 365 days from the date of the covered service(s), except as noted in Section 3.2.2.
- Ensure that enrollees are not billed for any amounts above the maximum allowed charge.
- The enrollee responsibility cannot always be determined at the time of the visit. Therefore, UMP prefers that providers collect applicable deductibles and coinsurance amounts from UMP enrollees after receiving the detail of remittance documenting the enrollee responsibility.

4.1.3 Referrals and Authorizations

Call 425-686-1246 or 1-800-464-0967

- Refer enrollees to UMP network providers and network facilities, except where no appropriate network provider is available or in case of an emergency.
- An online provider directory of network providers by city and specialty is available on the UMP Web site at **www.ump.hca.wa.gov**. In the directory, it is noted whether the network provider is board certified and if they are not accepting new patients. Network home health and hospice agencies, including infusion therapy providers, are listed in the directory by counties served. Searching for network providers within a specified travel distance from an enrollee's home can be done with the links to driving directions and maps by MapQuest provided.

  The online directory is updated twice a month. Non-network providers can apply for network status by contacting UMP. All providers must meet UMP selection criteria prior to receiving network provider status. Because the UMP's provider network continues to expand, it is important to verify a provider's network status by contacting UMP Customer Service at 425-686-1246 or 1-800-464-0967 prior to referring patients to that provider. If you notice that the information listed for you on our Web site is not accurate, please call Provider Services at 1-800-292-8092 or send updates via e-mail to **umpprovider@hca.wa.gov**.
- Call UMP to preauthorize the procedures identified in Section 6.1.3.
- Notify UMP by phone of the hospital admission diagnoses listed in Section 6.1.2.
- See Section 6 of this manual for detailed information about UMP utilization review requirements. In addition, see the UMP *Certificates of Coverage*, which list preauthorization requirements, covered benefits, exclusions, and limitations to benefits.

Section 5

Enrollee Responsibilities

Patient questions regarding benefits, network provider status, or claims payment? Call 1-800-762-6004 (active employees) or 1-800-352-3968 (retirees).

5.1

Enrollee Requirements

Enrollee education is an important factor in ensuring the timely and appropriate payment of health care benefits. UMP enrollees are instructed to follow these guidelines when obtaining health care services:

- Choose a provider from the *Network Provider Directory* as found on the UMP Web site at **www.ump.hca.wa.gov**, or call UMP Customer Service.
- Verify that the services they are obtaining are covered by UMP by referring to their UMP *Certificates of Coverage*, or by calling UMP.
- Identify themselves as a UMP enrollee when calling for an appointment.
- Present their identification card at the time services are rendered.
- Remind their physician to refer them to UMP network providers and to admit them to UMP network hospitals.
- Obtain preauthorization from UMP for:
  - Cardiac and pulmonary rehabilitation.
  - Certain injectable drugs that are not normally approved for self-administration, when obtained through a retail pharmacy or UMP's mail-service pharmacy (these drugs are indicated on the *UMP Preferred Drug List*).
  - Cochlear implants.
  - Durable medical equipment, supplies, and prostheses for rentals beyond three months or purchases over $1,000.
  - Genetic testing (except when associated with pregnancy or when associated with treatment decisions for a condition already diagnosed. Authorization may be granted only for testing performed by a specialist center/provider designated by UMP).
  - Home health care in which visits are daily or expected to exceed two hours a day, or when the length of treatment is expected to last more than three weeks. Reauthorization is required every two weeks unless determined otherwise by Medical Review. (Please call 1-888-759-4855 prior to the start of home health services in these cases.)
  - Hospice care (in order to be covered at the highest benefit level).
  - Inpatient admissions for rehabilitation (physical, occupational, and speech therapy).
  - Massage therapy in excess of one hour per treatment.
  - Mental health partial hospitalization services.
  - Negative pressure wound therapy pumps and related services.
  - Organ transplants: All organ transplants (including bone marrow, umbilical cord, and stem cell transplants). Patient must be accepted into the treating facility's transplant program and follow the program's protocol.
  - Positron emission tomography (PET) scans, except for diagnosis or staging of cancer.
  - Respite care.
  - Skilled nursing facility admissions.
  - Some prescription drugs (see the UMP Web site at **www.ump.hca.wa.gov** for an up-to-date list of drugs that require preauthorization).
  - Temporomandibular joint (TMJ) surgery.

In addition, some frequently prescribed durable medical equipment such as light

boxes, hospital beds, and breast pumps, are covered only when they have been determined to be medically necessary. It may be to your patient's benefit to request preauthorization on these items.

- Promptly remit applicable deductibles, coinsurance, copayments, and/or payment for noncovered services.

If your patients have questions regarding benefits, network provider status, or payment of their claims, please refer them to UMP at the above-referenced numbers.

Section 6

Utilization Review

Notification/preauthorization questions? Call 425-686-1246 or 1-800-464-0967.

6.1

Utilization Review Requirements

6.1.1 Overview

UMP Medical Review professionals perform utilization and quality review, as well as case management services for our enrollees.

To notify UMP of hospital admissions, (see Section 6.1.2), preauthorize services (see Section 6.1.3), or determine eligibility, call the numbers at the beginning of this section.

UMP's utilization management program includes review of certain medical services before, during, and after they are delivered. Reviews are conducted for:

- Optional case management (selected complex or high-expense cases);
- Notifying UMP of certain diagnoses (see Section 6.1.2);
- Required case management; and
- Retrospective (postpayment) review.

The purpose of the review is to determine whether or not services are medically necessary and delivered in the most appropriate setting. Such reviews help to:

- Monitor quality of care;
- Ensure that treatment is necessary and consistent with good medical practices;
- Discourage unnecessary care;
- Save health care dollars; and
- Identify chronic and catastrophic cases appropriate for case management.

6.1.2 Notification of Hospital Admissions

The purpose of this program is to allow UMP the earliest possible identification of patients for whom case management services may be appropriate. Please notify UMP about patients with complex medical conditions like:

- Cancer
- Chemical dependency
- Chronic respiratory disease
- Congenital defects
- Congenital heart disease
- CVA (cerebrovascular accident/stroke)
- Diabetes
- HIV disease
- Ischemic heart disease/peripheral vascular disease
- Neonatal complications
- Neurodegenerative disorders (multiple sclerosis, amyotrophic lateral sclerosis, muscular dystrophy)
- Organ transplant, including stem cell and bone marrow
- Pregnancy (complications of)
- Spinal cord injury
- Trauma (multiple trauma, head injury)
- Any hospital stay exceeding 10 days

The medical condition of the enrollee will be evaluated to determine if case management is indicated. Notification is not necessary when Medicare or another plan requiring prior notification/preauthorization is the primary payer.

Note: The notification process does not involve approval for medical necessity or preauthorization of services. These admissions may be subject to retrospective (postpayment) review.

6.1.3 Preauthorization

To ensure that standard benefits are received by the enrollee, prior authorization by the plan must be received before you render the following services:

- Cardiac and pulmonary rehabilitation.
- Certain injectable drugs that are not normally approved for self-administration, when obtained through a retail pharmacy or UMP's mail-service pharmacy

(these drugs are indicated on the *UMP Preferred Drug List*).
- Cochlear implants.
- Durable medical equipment, supplies, and prostheses for rentals beyond three months or purchases over $1,000.
- Genetic testing except when associated with pregnancy or when associated with treatment decisions for a condition already diagnosed. Authorization may be granted only for testing performed by a specialist center/provider designated by UMP).
- Home health care in which visits are daily or expected to exceed two hours a day, or when the length of treatment is expected to last more than three weeks. Reauthorization is required every two weeks unless determined otherwise by Medical Review. (Please call 1-888-759-4855 prior to the start of home health services in these cases.)
- Hospice care (in order to be covered at the highest level of benefit).
- Inpatient admissions for rehabilitation (physical, occupational, and speech therapy).
- Massage therapy in excess of one hour per treatment.
- Mental health partial hospitalization services.
- Negative pressure wound therapy pumps and related services.
- Organ transplants: All organ transplants (including bone marrow, umbilical cord, and stem cell transplants). Patient must be accepted into the treating facility's transplant program and follow the program's protocol.
- Positron emission tomography (PET) scans, except for diagnosis or staging of cancer.
- Respite care.
- Skilled nursing facility admissions.
- Some prescription drugs (see the UMP Web site at **www.ump.hca.wa.gov** for an up-to-date list of drugs that require preauthorization).
- Temporomandibular joint (TMJ) surgery.

In addition, some frequently prescribed durable medical equipment such as light boxes, hospital beds, and breast pumps, are covered only when they have been determined to be medically necessary. It may be to your patient's benefit to request preauthorization on these items.

See the UMP *Certificates of Coverage* for specific information on preauthorization requirements and scope of coverage of these benefits.

6.1.4 Requirements for Skilled Nursing Facilities (SNF)– Medicare-Approved Only

Medical review is required for skilled nursing facility admissions prior to payment. To request preauthorization, call UMP at the numbers at the beginning of this section.

Medical review is not required when Medicare or another plan that requires preauthorization is the primary payer and is providing benefits. If Medicare or another plan is denying coverage, or Medicare limits have been exceeded, medical review will be required by UMP.

At the time of medical review or preauthorization, all cases will be screened for referral to Case Management.

6.1.5 Case Management

6.1.5.1 Optional Case Management

Case management is a collaborative process that may include a UMP nurse case manager coordinating with hospitals, skilled nursing facilities, or other facilities by telephone or on-site visits. This will require the cooperation of the facility and the attending physician.

Generally, cases are identified as candidates for case management through the notification process. However, a facility or provider may suggest other patients with chronic or catastrophic illnesses for referral to case management. In this instance, the facility or provider should call 1-888-759-4855 to speak to a nurse case manager (see Section 6.1.2).

6.1.5.2 Required Case Management

The UMP Medical Director or his/her delegate may review an enrollee's medical records and evaluate whether the enrollee's use of medical services is unsafe,

potentially harmful, excessive, or medically inappropriate. Based on this review, UMP may require an enrollee to participate in and comply with a case management plan as a condition of continued payment for services under UMP.

Among other services, case management often includes designating a primary provider to coordinate care, and designating a single hospital and pharmacy to provide covered services or medications. UMP has the right to deny payment for any services received outside the required case management plan with the exception of medically necessary emergency services provided outside the service area.

6.1.6 Retrospective Review

Certain admissions and services may be subject to retrospective (postpayment) review. This process involves an assessment of the:

- Medical necessity of the admission and/or procedure(s) performed;
- Appropriateness of the treatment setting or length of treatment;
- Patient's status upon discharge;
- AP-DRG validation;
- General quality of care delivered; and
- Validation of the procedure(s) and diagnoses codes submitted.

Providers and facilities are responsible for supplying any requested medical records or documentation required to complete these reviews. Failure to comply with such requests may result in denial of benefits.

6.1.7 Review Criteria and Quality Screens

UMP professional staff use multiple resources, including Medicare coverage criteria, payment policies, and manuals; and other national guidelines when conducting case reviews. In the majority of cases, UMP follows Medicare coverage and billing guidelines. If the nurse determines that a case does not meet the review criteria, the case will be referred to the UMP Medical Director. The decision to approve or deny is made by the UMP Medical Director after consultation with the attending physician, when appropriate, and is based on medical experience and expertise. Medical review criteria for individual cases will be provided on request.

Section 7

Payment Rules

Questions? Call 425-686-1246 or 1-800-464-0967.

7.1 General Information

7.1.1 *UMP PPO Certificate of Coverage*

The *UMP PPO Certificate of Coverage* (COC) (available on the UMP Web site at **www.ump.hca.wa.gov** or by calling 1-800-762-6004) is the official source of plan benefits and scope of coverage information. Throughout this section of the billing manual, key information from the COC that is pertinent to the benefit under discussion may be referenced for the provider's information. **Providers must rely on the COC itself to obtain full and complete information regarding the scope of coverage and benefit provisions.** Refer to the "How the UMP Works" section of the COC for a listing of provider types approved to deliver services.

7.1.2 Plan Payment Provisions for Providers

Unless otherwise specified in this manual or the COC, the enrollee's applicable calendar year deductible must be satisfied before the plan will make a payment for services provided under a given benefit.

Services exempt from the annual medical/surgical deductible include:

- Preventive care*;
- Retail and mail-order prescription drugs**;
- Routine vision exams and hardware;
- Required second surgical opinions; and
- Tobacco cessation services provided through the *Free & Clear* smoking cessation program.

**UMP follows the preventive care guidelines established by the U.S. Preventive Services Task Force (USPSTF) when determining coverage for preventive care. See Section 7.2.2, Preventive Care, for more information.*

***UMP PPO has a separate annual deductible for prescription drugs. It is a combined retail and mail-order deductible. See the* UMP PPO Certificate of Coverage *for more details.*

In the *UMP PPO Certificate of Coverage* and elsewhere, "non-network" and "out-of-network" refer to services from providers who are not contracted with UMP, Beech Street, or American WholeHealth Networks. "Non-network" is usually used to refer to situations where the enrollee had the opportunity to use a network provider but chose not to. "Out-of-network" refers to situations where the enrollee did not have access to a network provider, as determined by UMP. After the enrollee's annual medical/surgical deductible has been met, the plan's payment provisions generally are as follows:

- For **network providers**, the plan pays 90 percent of the allowed charge. (The "allowed charge" is the provider's billed charge or the applicable contracted fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 10 percent. (**Note:** A payment differential applies to certain categories of providers. This differential is described in Section 7.1.3.)
- For **non-network providers**, UMP pays 60 percent of the allowed charge. However, when the enrollee does not have access to a network provider, the plan pays at the out-of-network rate (80 percent of the allowed charge). (The "allowed charge"

is the provider's billed charge or the fee schedule amount in Washington, whichever is less. In all other states, the allowable is based on a regionally adjusted charge.) The enrollee is responsible for the coinsurance (40 percent or 20 percent), as well as any outstanding balance above UMP's allowed charge. Refer to the *UMP PPO Certificate of Coverage* for specific details regarding the payment provisions, plan benefits, and scope of coverage.

For network providers and when services have been paid at the out-of-network rate, these payment provisions are in effect until the enrollee's annual medical/surgical out-of-pocket limit or benefit limit is reached. However, even if the enrollee's annual medical/surgical out-of-pocket limit is reached, non-network providers who were reimbursed at the out-of-network rate can still balance bill enrollees for the difference between billed and allowed charges.

Services paid at the non-network provider rate are not applied towards the enrollee's annual medical/surgical out-of-pocket limit.

The payment provisions described above are in effect until the enrollee's lifetime maximum benefit limit is reached. Inpatient services are subject to inpatient hospital copayments or coinsurance. For additional details regarding payment provisions, plan benefits, and scope of coverage, see the *UMP PPO Certificate of Coverage.*

Note: *Through the Beech Street network (see directory at* **www.beechstreet.com**), UMP enrollees also have access *to network providers outside of Washington and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce.*

Also note: Services rendered under private contracts by providers who "opt out" of the Medicare program will not be covered or reimbursed by UMP. Exceptions are services provided on an emergency/urgent basis or that are excluded under the Medicare program, such as routine eye exams and preventive care services/procedures, which will be processed and paid according to UMP benefits. In a private contract situation, the UMP enrollee is solely responsible for the provider's total billed charges.

7.1.3 Payment Differential Policies

7.1.3.1 Provider Type Payment Differentials

A payment differential applies to services rendered by certain categories of providers. The plan allowed charge for covered services provided by the following providers is the lesser of the provider's billed charge or 90 percent of the applicable UMP *Professional Provider Fee Schedule* amount.

- Certified nurse midwives
- Licensed midwives
- Licensed advanced registered nurse practitioners
- Licensed masters of social work (LMSW)
- Licensed mental health counselors (LMHC)
- Licensed marriage and family therapists (LMFT)
- Licensed physician assistants (PA)*

The plan allowed charge for covered services provided by the following provider type is the lesser of the providers' billed charge or 80 percent of the applicable UMP *Professional Provider Fee Schedule* amount.

- Registered Nurse First Assistants, licensed and certified (CRNFA)**

Enrollee cost-sharing provisions then apply to the above-referenced provider's allowed charge.

**The employer (physician or physician clinic/group) must bill services provided by licensed physician assistants (PA) for UMP coverage and payment consideration, as UMP does not credential or reimburse PAs directly. The CMS-1500 claim form must include the employer's tax I.D. number in field 25, PA's name in field 31, and the employer's name/address in field 33.*

***Services provided by CRNFAs are covered only where an assistant at surgery is payable by the plan. For payment consideration, the CRNFA's services must be billed by the supervising physician. UMP will not reimburse CRNFAs directly at any time. The CMS-1500 claim form must include the supervising physician's tax I.D. number in field 25, the CRNFA's name in field 31, and the supervising physician's name/address in field 33.*

Note: UMP will not cover any services provided by an RNFA who is not certified.

Refer to the UMP *Certificates of Coverage* for payment provisions and specific details on plan benefits and scope of coverage.

Please note: Payment differentials for the categories of providers stated in this section may be subject to change based on Medicare guidelines.

7.1.3.2 Site of Service Payment Differentials

UMP applies a site of service payment differential based on Medicare's dual resource-based practice expense relative value units (RVUs) and payment policy. The resource-based relative value scale (RBRVS) maximum allowances on the UMP *Professional Provider Fee Schedule* are determined using Medicare's three RVU components (work, practice expense, and malpractice expense).

Many procedure codes have two discrete levels of practice expense RVUs: facility setting and non-facility setting. For this reason, the UMP *Professional Provider Fee Schedule* lists separate maximum allowances for professional services performed in these settings. There are:

- **Facility setting maximum allowances** apply when the professional services are performed in a facility setting and the cost of the resources are the responsibility of the facility; or
- **Non-facility setting maximum allowances** apply when the provider performing the services typically bears the overhead expenses and resource costs, such as labor, medical supplies, and medical equipment associated with the services performed.

The non-facility setting maximum allowances are used to reimburse professional services performed in all settings, except for the following settings where a separate payment is issued for facility charges:

- Ambulances
- Ambulatory surgery centers (ASC)*
- Licensed birthing centers
- Community mental health centers
- Hospice facilities
- Hospitals
- Indian health facilities
- Military facilities
- Skilled nursing facilities
- Tribal facilities

In these settings, the facility setting maximum allowances, which exclude the allowance for facility overhead expenses and resource costs, are used to reimburse professional services.

UMP does not provide separate payment for facility charges when the non-facility setting maximum allowances are used, such as for services performed in physician offices and surgical suites. UMP reimburses for these expenses within the practice expense component of the non-facility setting maximum allowance for the professional service, which includes facility overhead costs.

**An ASC facility must be licensed by the state(s) in which it operates, unless that state does not require licensure. In addition, the facility must be Medicare-certified or be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or have accreditation as an ASC by another national accrediting organization recognized by UMP.*

Some services, by nature of their description, are performed only in certain settings and have only one maximum allowable fee per code. Examples of these services include many evaluation and management codes, which specify the site of service within the description of the procedure codes; and major surgical procedures that are generally performed only in hospital settings.

Please note: Following Medicare's consolidated billing requirements, UMP does not make a separate payment to the performing provider for therapies (such as physical therapy, occupational therapy, and speech therapy) provided in hospitals or skilled nursing facilities. In these settings, the facilities must submit a consolidated bill for the therapies provided. Since a single payment is issued to the facility only, UMP reimbursement for the therapies to the facilities is based on the non-facility setting maximum allowable fees, which include facility overhead expenses and resource costs.

Professional claims without a valid Medicare 2-digit place of service code will be denied. Refer to

Section 3.1 of this manual for a list of the place of service codes.

7.1.4 Patient's Financial Responsibility

Network providers agree to accept the UMP allowed amount as full compensation for covered services, and agree not to bill enrollees for any amounts above the contracted allowed amount.

Except as provided below or in your network provider agreement, the patient can be billed for:

- Any applicable deductible, co-payment, or coinsurance;
- Any charges for services specifically excluded in the applicable UMP *Certificate of Coverage*; or
- Any charges for services that exceed benefit limits, in the case of benefits with specific visit, day, or dollar limits.

The patient **cannot** be billed for:

- Any amounts above the UMP allowed amount;
- Any supplies or procedures that are included ("bundled") in the UMP allowed amounts for other services;
- Any amounts for which UMP is responsible; or
- Any services that UMP determines are not or were not medically necessary, including services determined by UMP to be experimental or investigational. An exception to this requirement is made if the patient understood, prior to receiving the service, that the specific service would not be covered by UMP, and agreed in writing to assume financial responsibility for the service.

The enrollee cost-sharing responsibility cannot always be determined at the time of the visit. Therefore, UMP prefers that providers collect applicable deductibles, copayments, and coinsurance amounts from UMP enrollees after receiving the detail of remittance documenting the enrollee responsibility.

7.1.5 Modifiers

7.1.5.1 Modifiers That May Affect Payment

Only valid CPT® and HCPCS level II modifiers should be used when billing UMP for provider services. The following modifiers may affect payment for UMP claims. While other valid CPT® and HCPCS level II modifiers may be used for informational purposes, they do not affect payment. Modifiers for anesthesia services can be found in Section 7.10.3.

	Description of Modifier
22	Unusual services
24	Unrelated evaluation and management (E&M) services by the same physician during a postoperative period
25	Significant, separately identifiable E&M service by the same physician on the same day of a procedure or other service
26	Professional component
50	Bilateral procedure
51	Multiple procedures
54	Surgical care only
55	Postoperative management only
56	Preoperative management only
57	Decision for surgery
58	Staged or related procedure or service by same physician during the postoperative period
59	Distinct procedural service
62	Two surgeons
66	Surgical team
78	Return to O.R. for related procedure during postoperative period
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon (when qualified resident surgeon not available)
99	Multiple modifiers which may affect payment
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
TC	Technical component

These modifiers are explained in more detail under the appropriate service headings on the following page.

7.1.5.2 Requirements for Submission of Supporting Documentation for Modifiers

All claims with modifiers **22**, **51**, **62**, and **66** are individually reviewed prior to payment.

An operative report and/or other supporting documentation must be submitted with the claim for review when submitting modifier **22**.

When modifier **51** is used and more than five procedures are reported, supporting documentation is required with the incoming claim. When fewer than five procedures are reported, the operative report and/or other supporting documentation is not required with the incoming claim, but may be requested if needed during the payment review.

For claims with modifiers **62** and **66** the operative report and/or other supporting documentation is not required with the incoming claim, but may be requested if needed during the payment review.

Supporting documentation (including medical records) for using other modifiers (such as modifier **25** and **59**) is required only if requested by UMP or the claims administrator.

7.1.6 Documentation Requirements for Unlisted Procedures

All claims with unlisted CPT® and/or HCPCS level II codes must be accompanied by supporting documentation. Unlisted codes generally end with "99" or "9" in the last digits of the CPT® code. Supporting documentation for the different categories of services is defined as follows.

Type of Unlisted Service	Unlisted CPT® Codes Within This Range	Type of Supporting Documentation
Surgical procedures	15999 to 69979	Operative report
Radiology	76496 to 79999	Clinic or office notes, x-ray report, and/or written description on or attached to the claim
Laboratory	80299 to 89240	Laboratory or pathology report and/or written description on or attached to the claim
Medicine	90399 to 99199 and 99600	Written description on or attached to the claim
Evaluation and management	99429 and 99499	Daily office notes and/or written description on or attached to the claim
Drugs and biologicals (administered by the professional provider)	J3490 – J9999	Name, manufacturer, strength, dosage, and quantity of the drug. If there is a specific drug code available, it should be used instead of an unclassified or unspecified drug code. **Note:** Codes J8499 and J8999 for oral drugs are generally not covered.

Unlisted HCPCS level II codes can be identified when the following terms are used to define them: "Unlisted, not otherwise classified (NOC), unspecified, unclassified, other, and miscellaneous." Use the appropriate unlisted procedure code, and provide a written description of the item or service on or attached to the claim.

7.2

Medical Visits and Consultations

7.2.1 Office, Clinic, and Hospital Visits

All office, hospital, clinic, skilled nursing facility, and home visits by approved provider types for the diagnosis or treatment of covered conditions are covered under this benefit, subject to any specific plan limitations on the services being provided. Please refer to the UMP *Certificates of Coverage* for details regarding the scope of coverage of these benefits.

7.2.2 Preventive Care

Routine physical exams as recommended by the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services are covered by UMP. UMP preventive care benefits include screening mammograms, well-baby care, and other services provided specifically to monitor and maintain the patient's health and/or prevent illness. The benefit is based on recommendations of the U.S. Preventive Services Task Force as well as the National Immunization Program of the Centers for Disease Control and Prevention, and recently published peer-reviewed literature on preventive care. Refer to the *Certificates of Coverage* for more details on specific preventive care benefits.

Annual exams (covered as preventive at 100%) are limited to once every 12 months. Women's preventive services may be provided by ***either*** an OB/GYN or a primary care physician.

When preventive care services are provided, the services must be coded as such for coverage/payment consideration under the UMP preventive care benefit.

Preventive medicine E&M services must be reported with the applicable CPT® procedure code (i.e., 99381–99397). When an abnormality is encountered or a preexisting problem is addressed during a preventive E&M service, and if it is significant enough to require additional work to perform the key components of a problem-oriented E&M service, providers may report the applicable CPT® office/outpatient E&M code (i.e., 99201–99215) in addition to the applicable preventive medicine E&M code for coverage/payment consideration. In this situation modifier 25 must be reported with the office/outpatient E&M code to indicate that a significant separately identifiable E&M service was provided.

A separate charge for an office/outpatient E&M code is not appropriate if an insignificant or trivial problem/abnormality is encountered during the preventive care visit that does not require additional work and performance of the key components of a problem-oriented E&M service.

When it is appropriate to bill both procedure codes, the preventive medicine E&M code will be paid according to the full UMP fee schedule amount and the office/outpatient E&M code will be paid according to a reduced rate that is based on the RVU work value only. These reduced rates are included in the *UMP Professional Provider Fee Schedule* on the Web site.

For additional coding information for preventive medicine E&M services, please refer to the current CPT® book.

Please be prepared to provide supporting documentation if requested. Medically unnecessary services are considered provider liability under the UMP *Network Provider Agreement*. Charges for preventive care services provided under the terms of this benefit are exempt from the enrollee's calendar year deductible. Except as described above, if a medical diagnosis is billed in addition to preventive medical services, the claim will not be processed as a preventive service and the enrollee's annual deductible and coinsurance may apply.

Coverage of routine vision care is discussed under the "Vision Care" section of the UMP *Certificates of Coverage*.

7.2.3 After Hours, Evening, and Holiday Services (CPT® Codes 99050–99060)

After hours office codes are payable in addition to other services only when the provider's office is not regularly open during the time the service is provided. After hours 24-hour facility codes are payable in certain situations where a provider is called to the facility to treat a patient. These codes are not payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists, laboratory clinical staff, or other providers who are paid to be on call at the time of service. The medical record must reflect the medical necessity and urgency of the service. Only one code for after hours services will be paid per patient per day, and a second "day" may not be billed for a single episode of care that carries over from one calendar day to the next.

CPT® Code	Brief Description
99050	Medical services after hrs
99053	Med serv 10pm-8am, 24 hr fac

UMP follows Medicare policy, which does not allow separate payment for the following CPT® codes. These codes are bundled on the fee schedule.

CPT® Code	Brief Description
99051	Med serv, eve/wkend/holiday
99056	Med service out of office
99058	Office emergency care

The following CPT® code is not separately payable, except in extenuating circumstances.

CPT® Code	Brief Description
99060	Out of office emerg med serv

7.2.4 Physician Team Conferences and Phone Consultations, Physician Standby Service, and Prolonged Evaluation and Management (E&M) Services

7.2.4.1 Physician Team Conferences and Physician Phone Consultations

CPT® codes 99361, 99362, 99371, 99372, and 99373 must be documented as medically necessary in the medical record. These procedures are not separately reimbursable if they result from, result in, or otherwise relate to another procedure billed by the same provider.

7.2.4.2 Physician Standby Service

CPT® code 99360 is used to report physician standby services requested by another physician that involve prolonged physician attendance without direct (face-to-face) patient contact. Please note the following guidelines for billing CPT® code 99360.

- The standby physician may not provide care to other patients during the period.
- CPT® code 99360 is not used to report time spent proctoring another physician.
- CPT® code 99360 is not reimbursable when the standby period ends with the performance of a procedure subject to a "surgical package" by the physician who was on standby.
- CPT® code 99360 is not reimbursable when billed in addition to any other procedure code, with the exception of CPT® codes 99291, 99292, 99431, or 99440, on the same day.
- CPT® code 99360 is used to report the total duration of time spent. Standby of less than 30 minutes is not reimbursed by UMP under any circumstances.
- Subsequent periods of standby beyond the first 30 minutes may be reported and are reimbursable only when a full 30 minutes of standby was provided for each unit of service reported. All fractions of a 30-minute time unit must be rounded downward.
- Claims for physician standby service must be accompanied by medical records at the time of submission to UMP.

7.2.4.3
Prolonged Evaluation and Management (E&M) Services

Payment of prolonged E&M codes (99354-99357) is allowed with a maximum of three hours per day per patient. The physician must be providing prolonged services involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting. These services are payable only when another E&M code is billed on the same day using the following criteria:

CPT® Code	Other CPT® Code(s) Required on Same Day
99354	99201–99205, 99212–99215, 99241–99245, or 99304–99350
99355	99354 and one of the E&M codes required for 99354
99356	99221–99223, 99231–99233, or 99251–99255
99357	99356 and one of the E&M codes required for 99356

The time counted toward payment for prolonged E&M services includes only direct face-to-face contact between the physician and the patient (whether the service was continuous or not). Physicians may not include time that a patient spends occupying an exam or treatment room while there is no direct contact between physician and patient, or time spent with a nonphysician "incident to a physician's service."

7.2.5
Modifiers for Evaluation and Management Services

Evaluation and management (E&M) services provided as part of a global package are generally included in the reimbursement of the procedure and are not separately reimbursable. However, the modifiers listed below identify services that are reimbursed separately if requirements are met. Supporting documentation such as medical records must be submitted to UMP upon request.

	Description of Modifier
24	**Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period** This modifier is used to indicate that an evaluation and management service was performed during a postoperative period that is not related to the surgical procedure.
25	**Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service** This modifier is used to indicate that, on the day of a procedure, a significant, separately identifiable related or unrelated E&M service was required due to the patient's condition.
57	**Decision for Surgery** This modifier indicates that the decision to operate was made during this E&M visit and separate payment should be made, even if the visit falls within the global surgery period.

7.3

Surgery

7.3.1 Surgical Services

Covered services under this benefit include those provided by the surgeon, assistant surgeon*, licensed physician assistant*, certified registered nurse first assistant*, and anesthesia provider in performing medically necessary surgery for a covered condition. Please refer to the UMP *Certificates of Coverage* for details regarding the scope of coverage of these benefits.

**When deemed medically necessary in the opinion of the plan.*

7.3.2 Global Surgery Rules

UMP follows Medicare's national definition of a global surgical package, in which a single fee is billed and paid for all necessary services, normally furnished by the surgeon before, during, and after the procedure. Under the payment policy, major procedures have a 90-day postoperative period. Minor surgeries and endoscopies have a 0- or 10-day postoperative period. UMP payment policy differs from Medicare's by having a 45-day postoperative period for some maternity care and delivery codes.

The applicable global day period for each procedure code is included on the UMP *Professional Provider Fee Schedule*, which can be downloaded from the UMP Web site at **www.ump.hca.wa.gov**. Surgical procedures are reimbursed according to the UMP fee schedule based on the RBRVS methodology.

The global surgery definition includes:

- The operation;
- Preoperative visits, in or out of the hospital, beginning on the day prior to surgery;
- Services by the primary surgeon, in or out of the hospital, during a standard postoperative period as described above;
- Dressing changes; local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral IV lines, and nasogastric and rectal tubes; and change and removal of tracheostomy tubes; and
- All additional medical or surgical services required because of complications that do not require additional trips to the operating room.

The global surgery definition does not include the initial evaluation, consultation, or preoperative visits prior to the day before surgery. Also excluded are postoperative visits for problems unrelated to the surgery or for services that are not included in the normal course of treatment for the surgery.

For endoscopic procedures and minor surgery where global surgical payment policy does not usually apply, payments are denied for an E&M service on the same day of the surgical or endoscopic procedure unless a documented, separately identifiable service is provided.

Claims for services that may be separately payable within the preoperative or postoperative period of a procedure must include the appropriate diagnosis codes and applicable procedure modifier (such as 24, 25, 57, 59, 76, 77, 78, or 79) for payment consideration. Supporting documentation must be provided to UMP upon request.

Please refer to Section 7.4 for information regarding the bundling of payment for supplies, surgical trays, and services provided in the physician's office.

7.3.3
Modifiers for Surgical Procedures

UMP follows Medicare's pricing rules for the CPT® surgical modifiers listed below.

Surgical Modifier

50 Bilateral Procedure

The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. For surgical procedures typically performed on one side of the body that are, in a specific case, performed bilaterally, the maximum allowance is 150 percent of the global surgery fee schedule amount for the procedure. Providers must bill using the single procedure code with modifier 50.

51 Multiple Procedures

Multiple Surgeries: If multiple procedures are performed on the same patient at the same operative session or on the same day, the total maximum allowance is equal to the sum of the following: One hundred (100) percent of the global fee schedule amount for the highest fee-schedule-valued procedure and fifty (50) percent of the global fee schedule amount for the second through fifth procedures. Surgical procedures in excess of five require submission of supporting documentation and individual review to determine payment amount. ***Multiple Endoscopies:*** Related endoscopic procedures performed on the same day are subject to the multiple endoscopy rule. The maximum allowance for the procedure with the highest fee schedule value is the full fee schedule amount. The maximum allowance for the second procedure is the full fee schedule amount minus the fee schedule amount for its base diagnostic endoscopy procedure. Unrelated endoscopic procedures performed on the same day are subject to the regular multiple surgery rule instead of the multiple endoscopy rule, since the codes are not in the same procedure family. The maximum allowance for the procedure with the highest fee schedule value is the full fee schedule amount, and the second procedure is allowed at 50 percent of the fee schedule amount.

If multiple related endoscopies (e.g., upper and lower gastrointestinal endoscopies) are performed on the same day, the special multiple endoscopy rules are applied separately within each group, and the multiple surgery rules are applied between groups.

Please note: Providers should not discount their billed charges for multiple procedures. The appropriate discount as indicated above is applied to the maximum allowances by UMP.

54, 55, & 56 Providers Furnishing Less than the Global Surgical Package

These modifiers are designed to ensure that the sum of all maximum allowances for all practitioners who furnished parts of the services included in a global surgery fee schedule allowance do not exceed the total amount that would have been allowed to a single practitioner. The payment policy pays each provider directly for the portion of the global surgery services furnished to the enrollee. UMP follows Medicare's pre-, post-, and intraoperative percentages as published in the *Medicare Physician Fee Schedule Data Base.* For split-care, there must be an agreement for the transfer of care between the surgeon and provider who will provide pre- and/or postoperative care. Postoperative care is paid according to the number of days each provider is responsible for the patient's care and must be agreed upon by each provider so each provider bills the correct number of days. The three modifiers used are:

54 Surgical Care Only
This modifier is used by the surgeon when he/she is performing only the preoperative and intraoperative care. Payment is limited to the amount allotted to the preoperative and intraoperative services.

55 Postoperative Management Only
This modifier must be used when a provider other than the operating surgeon assumes responsibility for the postoperative care of the patient. When submitting charges, the same CPT® code that the surgeon used should be billed with modifier 55. The postoperative care is paid at a percentage of the physician's fee schedule. The receiving provider cannot bill for any part of the service included in the global period until he/she provides at least one service. The receiving provider must bill postoperative care as one lump sum.

56 Preoperative Management Only
This modifier is used by a provider who performs the preoperative care and evaluation and who is not the operating surgeon. Payment is limited to the amount allotted to the preoperative services.

Surgical Modifier

58 Staged or Related Procedure or Service by Same Physician During the Postoperative Period

This modifier is used when a surgical procedure is performed during the postoperative period of another surgical procedure because the subsequent procedure: a) was planned at the time of the original procedure; b) was more extensive than the original procedure; or c) was for therapy following a diagnostic surgical procedure.

59 Distinct Procedural Service

This modifier represents procedure(s) or service(s) not ordinarily performed or encountered on the same day by the same provider, but that are appropriate under certain circumstances (e.g., different site or organ system, or separate excision or lesion). Supporting documentation may be requested for review.

62 Two Surgeons

For surgery requiring the skills of two surgeons (each with a different specialty), the maximum allowance for each surgeon is 62.5 percent of the global surgical fee schedule amount. No payment is made for an assistant-at-surgery in these cases.

66 Team Surgery

This modifier is used when highly complex procedures are carried out by a surgical team, which may include the concomitant services of several physicians, often of different specialties; other highly skilled, specially trained personnel; and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. **Supporting documentation may be requested for review.**

76 Repeat Procedure by Same Physician

This modifier is used to indicate that a procedure or service was repeated subsequent to the original procedure or service.

77 Repeat Procedure by Another Physician

This modifier is used to indicate that a procedure or service performed by another physician had to be repeated.

78 Return to O.R. for Related Surgery During Postoperative Period

Use of this modifier allows separate payment for procedures associated with complications from surgery. The maximum allowance is limited to the amount allotted for intraoperative services only.

80, 81, 82, & AS Assistant-at-Surgery

Four modifiers may be used to identify procedures where a second provider assists another in the procedure. They are:

80 - Assistant Surgeon
81 - Minimum Assistant Surgeon
82 - Assistant Surgeon (when qualified resident surgeon is not available)
AS - Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery.
Note: "AS" is also the appropriate modifier for certified registered nurse first assistant claims.

The maximum allowance for procedures with these modifiers is the lower of the following:

- Actual charge; or
- Twenty (20) percent of the global surgery fee schedule amount for the procedure.

Multiple surgery rules apply to subsequent multiple procedures.

Provider payment differentials described in Section 7.1.3 of this manual apply to maximum allowances for services reported with modifier AS.

Other Related Modifiers

22	**Unusual Services** Procedures with this modifier are individually reviewed prior to payment. An operative report and/or other supporting documentation must be submitted with the claim for review.
24	**Unrelated Evaluation and Management (E&M) Services by the Same Physician During a Postoperative Period** This modifier is used to indicate that an evaluation and management service was performed during a postoperative period that is not related to the surgical procedure. Supporting documentation may be requested for review.
25	**Significant, Separately Identifiable Evaluation and Management (E&M) Service by the Same Physician on the Same Day of a Procedure or Other Service** This modifier is used to indicate that, on the day of a procedure or other service, a significant, separately identifiable, related or unrelated E&M service was required due to the patient's condition. Supporting documentation may be requested for review.
99	**Multiple Modifiers** Under certain circumstances, two or more modifiers may be necessary to completely delineate a service. For procedures where more than two modifiers which affect payment apply, modifier "99" should be added to the base procedure and other applicable modifiers listed as part of the service description. The claim is individually reviewed prior to payment. Supporting documentation may be requested for review.

7.4

Bundled Surgical Trays, Supplies, and Services

Services and supplies provided under this benefit must be medically necessary and must be prescribed by an approved provider type for the direct treatment of a covered condition. Please refer to the UMP *Certificates of Coverage* for details regarding the scope of coverage of these benefits.

7.4.1 Surgical Trays Used in the Provider's Office

UMP does not provide separate payment for surgical trays reported under HCPCS code A4550. With the implementation of Medicare's resource-based practice expense relative value units and payment policy, the reimbursement for surgical trays is included in the UMP payment for the procedure. Refer to Section 7.4.2 for information on bundled supplies.

The UMP *Billing & Administrative Manual* contains abbreviated definitions of procedure codes. For billing purposes, please refer to the most current edition of the CPT® and HCPCS books for complete descriptions of the procedure codes.

7.4.2 Bundled Supplies

Under the UMP fee schedule RBRVS methodology, many supply items are considered "bundled" into the cost of other services (associated office visits or procedures), and are not paid separately.

Please note: Items with an asterisk (*) on the following list are considered prosthetics when used for a permanent condition and may be paid separately for permanent conditions if they are provided in the physician's office. They are not considered prosthetics if the condition is acute or temporary. Examples are Foley catheters and accessories for permanent incontinence, or ostomy supplies for permanent conditions. A catheter used to obtain a urine specimen after surgery, or a Foley catheter used to treat an acute obstruction would not be paid separately because they are treating a temporary problem. If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed which required the physician to replace the Foley, the catheter would be considered a prosthesis and be paid separately.

Items with two asterisks (**) on the following list are surgical dressings that are not separately reimbursable when applied by a provider during the course of a procedure or an office visit. The cost for the surgical dressings is included in the practice expense component of the relative value unit for the professional service. Primary and secondary surgical dressings dispensed *for home use* are reimbursed separately when billed with place of service "12" (home).

Bundled supplies that are ***not*** paid separately are listed below.

Bundled Supplies

CPT® Code	Brief Description
99070	Special supplies
A4206	Syringe with needle, sterile 1 cc
A4207	Syringe with needle, sterile 2 cc
A4208	Syringe with needle, sterile 3 cc
A4209	Syringe with needle, sterile 5 cc
A4211	Supplies for self-administered injections
A4212	Non-coring needle or stylet
A4213	Syringe; sterile, 20 cc or greater
A4215	Needles only, sterile, any size*
A4216	Sterile water/saline, 10 ml*
A4217	Sterile water/saline, 500 ml
A4218	Sterile saline or water
A4220	Refill kit for implantable infusion pump
A4244	Alcohol or peroxide
A4245	Alcohol wipes
A4246	Betadine or pHisoHex solution
A4247	Betadine or iodine swabs/wipes
A4248	Chlorhexidine antisept
A4253	Blood glucose test or reagent strips for home glucose monitor

Bundled Supplies

CPT® Code	Brief Description
A4256	Normal, low, and high calibrator solution/chips
A4258	Spring-powered device for lancet
A4259	Lancets
A4262	Temporary absorbable lacrimal duct implant
A4263	Permanent tear duct plug
A4265	Paraffin
A4270	Disposable endoscope sheath
A4300	Cath impl vasc access portal
A4301	Implantable access total system; catheter, port/ reservoir, percutaneous access
A4305	Disposable drug delivery system, flow rate 50 ml or more per hour
A4306	Disposable drug delivery system, flow rate 5 ml or less per hour
A4310	Insertion tray without drainage bag*
A4311	Insertion tray without drainage bag*
A4312	Insertion tray without drainage bag*
A4313	Insertion tray without drainage bag*
A4314	Insertion tray with drainage bag*
A4315	Insertion tray with drainage bag*

Bundled Supplies

CPT® Code	Brief Description
A4316	Insertion tray with drainage bag*
A4320	Irrigation tray with bulb or piston syringe*
A4322	Irrigation syringe, bulb, or piston*
A4326	Male external catheter*
A4327	Female external urinary collection*
A4328	Female external urinary collection*
A4330	Peri-anal fecal collection pouch*
A4331	Extension drainage tubing*
A4332	Lubricant for cath insertion*
A4333	Urinary cath anchor device*
A4334	Urinary cath leg strap*
A4335	Incontinence supply, miscellaneous*
A4338	Indwelling catheter, Foley type*
A4340	Indwelling catheter, specialty type*
A4344	Indwelling catheter, Foley type*
A4346	Indwelling catheter, Foley type*
A4348	Male external cath extended wear*
A4349	Disposable male external cat*
A4351	Intermittent urinary catheter*
A4352	Intermittent urinary catheter*
A4353	Intermittent urinary catheter, with insertion supplies*
A4354	Insertion tray with drainage bag*
A4355	Irrigation tubing set*
A4356	External urethral clamp device*
A4357	Bedside drainage bag, day or night*
A4358	Urinary leg bag, vinyl*
A4359	Urinary suspensory without leg bag*
A4361	Ostomy faceplate*
A4362	Skin barrier; solid, 4 x 4*
A4363	Ostomy clamp, replacement*
A4364	Adhesive for ostomy or catheter*
A4365	Ostomy adhesive remover wipes*
A4366	Ostomy vent*
A4367	Ostomy belt*
A4368	Ostomy filter, any type *

Bundled Supplies

CPT® Code	Brief Description
A4369	Skin barrier liquid per oz*
A4371	Skin barrier powder per oz*
A4372	Skin barrier powder per oz*
A4373	Skin barrier solid 4x4 equiv*
A4375	Drainable plastic pch w/ fcpl*
A4376	Drainable rubber pch w/ fcplt*
A4377	Drainable plstic pch w/o fp*
A4378	Drainable rubber pch w/o fp*
A4379	Urinary plastic pouch w/ fcpl*
A4380	Urinary rubber pouch w/ fcplt*
A4381	Urinary plastic pouch w/o fp*
A4382	Urinary hvy plstc pch w/o fp*
A4383	Urinary rubber pouch w/o fp*
A4384	Ostomy faceplt/silicone ring*
A4385	Ost skn barrier sld ext wear*
A4387	Ost clsd pouch w/ att st barr*
A4388	Drainable pch w/ ex wear barr*
A4389	Drainable pch w/ st wear barr*
A4390	Drainable pch ex wear convex*
A4391	Urinary pouch w/ ex wear barr*
A4392	Urinary pouch w/ st wear barr*
A4393	Urine pch w/ ex wear bar conv*
A4394	Ostomy pouch liq deodorant*
A4395	Ostomy pouch solid deodorant*
A4396	Peristomal hernia support blt*
A4397	Irrigation supply, sleeve*
A4398	Ostomy irrigation supply, bags*
A4399	Ostomy irrigation supply, cone/catheter*
A4400	Ostomy irrigation set*
A4402	Lubricant*
A4404	Ostomy rings*
A4405	Nonpectin based ostomy paste*
A4406	Pectin based ostomy paste*
A4407	Ext wear ost skn barr <=4sq*
A4408	Ext wear ost skn barr >4sq*
A4409	Ost skn barr w flng <=4sq*

Bundled Supplies

CPT® Code	Brief Description
A4410	Ost skn barr w flng >4sq*
A4411	Ost skn barr extnd =4sq*
A4412	Ost pouch drain high output*
A4413	2 pc drainable ost pouch*
A4414	Ostomy sknbarr w flng <=4sq*
A4415	Ostomy sknbarr w flng >4sq*
A4416	Ost pch clsd w barrier/filtr*
A4417	Ost pch w bar/bltinconv/fltr*
A4418	Ost pch clsd w/o bar w filtr*
A4419	Ost pch for bar w flange/flt*
A4420	Ost pch clsd for bar w lk fl*
A4421	Ostomy supply, miscellaneous*
A4422	Ostomy pouch absorbent material*
A4423	Ost pch for bar w lk fl/fltr*
A4424	Ost pch drain w bar & filter*
A4425	Ost pch drain for barrier fl*
A4426	Ost pch drain 2 piece system*
A4427	Ost pch drain/barr lk flng/f*
A4428	Urine ost pouch w faucet/tap*
A4429	Urine ost pouch w bltinconv*
A4430	Ost urine pch w b/bltin conv*
A4431	Ost pch urine w barrier/tapv*
A4432	Os pch urine w bar/fange/tap*
A4433	Urine ost pch bar w lock fln*
A4434	Ost pch urine w lock flng/ft*
A4450	Non-waterproof tape*
A4452	Waterproof tape*
A4455	Adhesive remover or solvent*
A4462	Abdominal dressing holder/binder**
A4465	Non-elastic binder for extremity
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4550	Surgical trays
A4556	Electrodes (e.g., apnea monitor)
A4557	Lead wires (e.g., apnea monitor)
A4558	Conductive paste or gel
A4649	Surgical supply; miscellaneous

Bundled Supplies

CPT® Code	Brief Description
A4927	Non-sterile gloves
A4930	Sterile gloves per pair
A5051	Pouch, closed; with barrier*
A5052	Pouch, closed; without barrier*
A5053	Pouch, closed; use on faceplate*
A5054	Pouch, closed; use on barrier*
A5055	Stoma cap*
A5061	Pouch, drainable; with barrier*
A5062	Pouch, drainable; without barrier*
A5063	Pouch, drainable; use on barrier*
A5071	Pouch, urinary; with barrier*
A5072	Pouch, urinary; without barrier*
A5073	Pouch, urinary; use on barrier*
A5081	Continent device, plug*
A5082	Continent device, catheter*
A5093	Ostomy accessory, convex insert*
A5102	Bedside drainage bottle*
A5105	Urinary suspensory, with leg bag*
A5112	Urinary leg bag, latex*
A5113	Leg strap; latex*
A5114	Leg strap, foam or fabric*
A5120	Skin barrier, wipe or swab*
A5121	Skin barrier; solid, 6 x 6*
A5122	Skin barrier; solid, 8 x 8*
A5126	Adhesive, disc or foam pad*
A5131	Appliance cleaner*
A5200	Percutaneous catheter anchor*
A6010	Collagen based wound filler**
A6011	Collagen gel/paste wound fill**
A6021	Collagen dressing <=16 sq in**
A6022	Collagen drsg >16<=48 sq in**
A6023	Collagen dressing >48 sq in**
A6024	Collagen drsg wound filler**
A6025	Silicone gel sheet**
A6154	Wound pouch**
A6196	Alginate dressing, up to 16 sq. in.**
A6197	Alginate dressing, 16+ to 48 sq. in.**

Bundled Supplies

CPT® Code	Brief Description
A6198	Alginate dressing, 48+ sq. in.**
A6199	Alginate dressing, wound filler**
A6200	Composite dressing up to 16 sq. in. no bdr**
A6201	Composite dressing 16+ to 48 sq. in. no bdr**
A6202	Composite dressing 48+ sq. in. no bdr**
A6203	Composite dressing, up to 16 sq. in.**
A6204	Composite dressing, 16+ to 48 sq. in.**
A6205	Composite dressing, 48+ sq. in.**
A6206	Contact layer, up to 16 sq. in.**
A6207	Contact layer, 16+ to 48 sq. in.**
A6208	Contact layer, 48+ sq. in.**
A6209	Foam dressing, 16 sq. in. or less**
A6210	Foam dressing, 16+ to 48 sq. in.**
A6211	Foam dressing, 48+ sq. in.**
A6212	Foam dressing, up to 16 sq. in.**
A6213	Foam dressing, 16+ to 48 sq. in.**
A6214	Foam dressing, 48+ sq. in.**
A6215	Foam dressing, wound filler**
A6216	Gauze, non-impregnated, non-sterile**
A6217	Gauze, non-impregnated**
A6218	Gauze, non-impregnated**
A6219	Gauze, non-impregnated**
A6220	Gauze, non-impregnated**
A6221	Gauze, non-impregnated**
A6222	Gauze, impregnated, other than water or normal saline**
A6223	Gauze, impregnated, other than water or normal saline**
A6224	Gauze, impregnated, other than water or normal saline**
A6228	Gauze, impregnated, water or normal saline**
A6229	Gauze, impregnated, water or normal saline**
A6230	Gauze, impregnated, water or normal saline**
A6231	Hydrogel dsg <=16 sq in**
A6232	Hydrogel dsg >16<=48 sq in**
A6233	Hydrogel dressing >48 sq in**
A6234	Hydrocolloid dressing, wound cover**
A6235	Hydrocolloid dressing, wound cover**
A6236	Hydrocolloid dressing, wound cover**

Bundled Supplies

CPT® Code	Brief Description
A6237	Hydrocolloid dressing, wound cover**
A6238	Hydrocolloid dressing, wound cover**
A6239	Hydrocolloid dressing, wound cover**
A6240	Hydrocolloid dressing, wound filler, paste**
A6241	Hydrocolloid dressing, wound filler, dry form**
A6242	Hydrogel dressing, wound cover**
A6243	Hydrogel dressing, wound cover**
A6244	Hydrogel dressing, wound cover**
A6245	Hydrogel dressing, wound cover**
A6246	Hydrogel dressing, wound cover**
A6247	Hydrogel dressing, wound cover**
A6248	Hydrogel dressing, wound filler, gel**
A6250	Skin sealants, protectants, moisturizers, ointments**
A6251	Specialty absorptive dressing**
A6252	Specialty absorptive dressing**
A6253	Specialty absorptive dressing**
A6254	Specialty absorptive dressing**
A6255	Specialty absorptive dressing**
A6256	Specialty absorptive dressing, wound cover**
A6257	Transparent film, 16 sq. in. or less**
A6258	Transparent film, 16+ to 48 sq. in.**
A6259	Transparent film, 48+ sq. in.**
A6260	Wound cleansers any type/size**
A6261	Wound filler, gel/paste, not otherwise classified**
A6262	Wound filler, dry form, not otherwise classified**
A6266	Gauze, impregnated, other than water or normal saline**
A6402	Gauze, non-impregnated, sterile**
A6403	Gauze, non-impregnated, sterile**
A6404	Gauze, non-impregnated, sterile**
A6407	Packing strips, non-impreg**
A6410	Sterile eye pad**
A6411	Non-sterile eye pad**
A6412	Occlusive eye patch**
A6441	Pad band w>=3" <5"/yd**
A6442	Conform band n/s w<3"/yd**

Bundled Supplies

CPT® Code	Brief Description
A6443	Conform band n/s w>=3"<5"/yd**
A6444	Conform band n/s w>=5"/yd**
A6445	Conform band s w <3"/yd**
A6446	Conform band s w>=3" <5"/yd**
A6447	Conform band s w >=5"/yd**
A6448	Lt compres band <3"/yd**
A6449	Lt compres band >=3" <5"/yd**
A6450	Lt compres band >=5"/yd**
A6451	Mod compres band w>=3"<5"/yd**
A6452	High compres band w>=3"<5"yd**
A6453	Self-adher band w <3"/yd**
A6454	Self-adher band w>=3" <5"/yd**
A6455	Self-adher band >=5"/yd**
A6456	Zinc paste band w >=3"<5"/yd**
A6457	Tubular dressing**
A9900	Supply/accessory/service
A9901	Delivery/set up/dispensing
L9900	Orthotic and prosthetic supply/accessory/ service
Q3031	Collagen skin test*
Q9958	HOCM <=149mg/ml iodine, 1ml
Q9959	HOCM 150-199mg/ml iodine, 1ml
Q9960	HOCM 200-249mg/ml iodine, 1ml
Q9961	HOCM 250-299mg/ml iodine, 1ml
Q9962	HOCM 300-349mg/ml iodine, 1ml
Q9963	HOCM 350-399mg/ml iodine, 1ml
Q9964	HOCM >=400mg/ml iodine, 1ml
V2797	Vis item/svc in other code

Please note: CPT® code 99070, which represents miscellaneous supplies provided by the physician, is not reimbursable by UMP. Providers must bill specific HCPCS level II codes for supplies, prosthetics, and durable medical equipment.

7.4.3 Bundled Services

Under the UMP fee schedule RBRVS methodology, the following are considered "bundled" into the costs of other procedures and are not separately paid.

Bundled Services

CPT® Code	Brief Description
0003T	Cervicography
0021T	Fetal oximetry, trnsvag/cerv
0031T	Speculoscopy
0032T	Speculoscopy w/direct sample
15850	Removal of sutures
20930	Spinal bone allograft
20936	Spinal bone autograft
22841	Insert spine fixation device
43752	Nasal/orogastric w/stent
78890	Nuclear medicine data proc
78890-26	Nuclear medicine data proc
78890-TC	Nuclear medicine data proc
78891	Nuclear med data proc
78891-26	Nuclear med data proc
78891-TC	Nuclear med data proc
90467	Immune admin o or n, < 8 yrs
90468	Immune admin o or n, addl < 8 yrs
90473	Immunization oral/intranasal
90474	Immunization oral/intranasal
90885	Psy evaluation of records
90887	Consultation with family
90889	Preparation of report
91123	Irrigate fecal impaction
92531	Spontaneous nystagmus study
92532	Positional nystagmus study
92533	Caloric vestibular test
92534	Optokinetic nystagmus
92605	Eval for nonspeech device rx
92606	Non-speech device service
92613	Endoscopy swallow tst (fees)
92615	Eval laryngoscopy sense tst
92617	Interprt fees/laryngeal test

Bundled Services

CPT® Code	Brief Description
93740	Temperature gradient studies
93740-26	Temperature gradient studies
93740-TC	Temperature gradient studies
93770	Measure venous pressure
93770-26	Measure venous pressure
93770-TC	Measure venous pressure
94150	Vital capacity test
94150-26	Vital capacity test
94150-TC	Vital capacity test
94760	Measure blood oxygen level[1]
94761	Measure blood oxygen level[1]
97010	Hot or cold packs therapy
97605	Neg press wound tx, < 50 CM
97606	Neg press wound tx, > 50 CM
99000	Specimen handling
99001	Specimen handling
99002	Device handling
99024	Post-op follow-up visit
99051	Med serv, eve/wkend/holiday
99056	Non-office medical services
99058	Office emergency care
99060	Out of office emerg med serv[2]
99080	Special reports or forms[3]
99090	Computer data analysis
99091	Collect/review data from pt
99100	Special anesthesia service
99116	Anesthesia with hypothermia
99135	Special anesthesia procedure
99140	Emergency anesthesia
99143	Mod cs by same phys, < 5 yrs
99144	Mod cs by same phys, 5 yrs +
99145	Mod cs by same phys add-on
99148	Mod cs diff phys < 5 yrs
99149	Mod cs diff phys, 5 yrs +
99150	Mod cs diff phys add-on
99173	Visual screening test
99339	Domicil/r-home care supervise

Bundled Services

CPT® Code	Brief Description
99358	Prolonged serv, w/o contact
99359	Prolonged serv, w/o contact
99374	Home health care supervision
99377	Hospice care supervision
99379	Nursing fac care supervision
A0800	Amb trans 7 p.m. – 7 a.m.
G0102	Prostate cancer screening; digital rectal exam (DRE)
G0117	Glaucoma scrn hgh risk direc[4]
G0118	Glaucoma scrn hgh risk direc[4]
G0269	Occulsive device in vein art
G0333	Dispense fee initial 30 day
G0372	MD service required for PMD
Q0510	Dispens fee immunosuppressive
Q0511	Sup fee antiem, antica, immuno
Q0512	Ps sup fee anti-can sub pres
Q0513	Disp fee inhal drugs/30 days
Q0514	Disp fee inhal drugs/90 days
R0076	Transportation of portable EKG
S0257	End of life counseling

[1] *Separate payment for CPT® codes 94760 and 94761 may be allowed if supporting documentation is submitted that shows no other service was provided/ billed on the same date of service.*

[2] *Separate payment for CPT® code 99060 may be allowed in extenuating circumstances.*

[3] *CPT® code 99080, which represents completion of special reports such as insurance forms, is not reimbursable by UMP. The patient is responsible for any charges for this service, as it is an excluded benefit.*

[4] *When no other payable service is reported, UMP will allow separate reimbursement of this procedure.*

7.5

Maternity Services

Obstetric services provided and billed by a licensed physician, advanced registered nurse practitioner, certified nurse midwife, licensed midwife, hospital, or birthing center are covered under this benefit, provided plan coverage is in force at the time services are received. The provider must be able to provide the full scope of obstetric services (prenatal, delivery, and postnatal) for UMP to provide coverage under this benefit, except in areas where there are provider access issues and prior authorization has been obtained. Prenatal diagnostic screening for congenital disorders is covered.

Nursery charges for the newborn infant(s) are also covered for the length of the mother's medically necessary childbirth-related hospital stay, provided the child is enrolled in accordance with PEBB provisions. Please refer to the "Obstetric and Newborn" section in the UMP *Certificates of Coverage* for more details on the benefit.

Charges for termination of pregnancy are covered. Charges for infertility services, in vitro fertilization, or artificial insemination are not covered.

Please refer to the UMP *Certificates of Coverage* for details regarding the scope of coverage of these benefits.

7.6

Mental Health and Chemical Dependency Services

7.6.1 Mental Health (Counseling) Services

Covered services under this benefit include inpatient and outpatient hospital, and professional services for treatment of neuropsychiatric, mental, or personality disorders, including eating disorders (bulimia and anorexia nervosa). Services must be provided by a licensed physician, licensed psychologist, advanced registered nurse practitioner, licensed master of social work (LMSW), licensed mental health counselor (LMHC), licensed marriage and family therapist (LMFT), licensed community mental health agency, or state hospital. Services of LMSWs, LMHCs, and LMFTs are covered only for evaluation, assessment, and treatment of mental and emotional disorders and psychopathology (see Section 7.1.3.1 for more information on coverage and payment differentials for these provider types). Please refer to the UMP *Certificates of Coverage* for details regarding the scope of coverage of these benefits and approved provider types. Payment rules follow.

7.6.1.1 Payment Rules for Psychotherapy and Psychological Services

1. Psychotherapy and psychological services must be reported with the appropriate procedure code from the Psychiatry section of the CPT® book.
2. Diagnostic psychological testing must be reported with the appropriate code (e.g., CPT® codes 96101–96120).
3. The pharmacological management service codes (e.g., CPT® code 90862 and HCPCS code M0064) may be billed only by those providers with prescriptive authority.
4. The pharmacological management service codes (e.g., CPT® code 90862 and HCPCS code M0064) are not reimbursed separately with an evaluation and management service (e.g., CPT® codes 99201–99350) or psychotherapy service (e.g., CPT® codes 90804–90829).
5. The following CPT® psychotherapy codes with "medical evaluation and management" included in the descriptor are not covered for licensed psychologists, LMSWs, LMHCs, or LMFTs: 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, and 90829.
6. More than one occurrence of a psychiatric diagnostic interview examination (e.g., CPT® code 90801) per patient per

year by the same provider is not reimbursed unless a different psychiatric condition arises.

7. A psychiatric diagnostic interview (e.g., CPT® code 90801) is not reimbursed separately on the same day as an interactive psychiatric diagnostic interview (e.g., 90802).
8. An individual psychotherapy, insight-oriented, behavior-modifying and/or supportive service (e.g., CPT® codes 90804–90809, 90816–90822) is not reimbursed separately on the same day as an interactive individual psychotherapy service (e.g., CPT® codes 90810–90815, 90823–90829).
9. Individual psychotherapy may be covered on the same day as group therapy (e.g., CPT® codes 90846–90857).
10. No payment is made for group psychotherapy (e.g., CPT® code 90853) on the same day as interactive group psychotherapy (e.g., CPT® code 90857).
11. CPT® codes 90885, 90887, and 90889 are bundled services. Therefore, separate reimbursement is not allowed for these codes.

7.6.2 Chemical Dependency Services

Chemical dependency is defined as repetitive use of alcohol or drugs to the extent that such use interferes with the user's social, psychological, or physical well-being. Chemical dependency does not include dependence on tobacco, caffeine, or food. Licensed substance abuse treatment facilities must be approved by UMP. Please refer to the UMP *Certificates of Coverage* for details regarding the scope of coverage and benefit limit.

7.7 Other Medical Services

7.7.1 Drugs Incident to Physician Services

Separate payment is allowed if the covered drug is:

- Administered incidental to a provider's professional service; and
- Commonly administered in an office or clinic setting.

This policy applies to immunizations, therapeutic or diagnostic injections, and chemotherapy administration services covered by the plan. Please see the UMP *Certificates of Coverage* for plan benefits and scope of coverage details.

Special plan payment rules for these services, and for the drugs incident to these services, are described in the following sections.

UMP generally follows Medicare's coding guidelines and payment policies for administration of covered drugs and biologicals. The *UMP Professional Provider Fee Schedule for Drugs and Biologicals* is available on the UMP Web site at **www.ump.hca.wa.gov**.

7.7.2 Immunizations

7.7.2.1 Service Coding and Reimbursement for Immunizations

The CPT® immunization administration codes may be reported in addition to the applicable CPT® immune globulin product codes and vaccine/toxoid product codes for payment consideration. The number of units reported in the units field on the claim for CPT® codes 90465 and 90471 should not exceed one. The applicable add-on procedure code (CPT® 90466 and 90472) may be reported when multiple immunizations are administered. If a significant, separately identifiable evaluation and management service is performed, the appropriate E&M code may be reported in addition to the immunization administration codes for payment consideration.

CPT® codes for immunization administration by intranasal or oral route are not separately payable.

The maximum allowances for covered CPT® immune globulin prod-

uct codes and vaccine/toxoid product codes are included in the *UMP Professional Provider Fee Schedule for Drugs and Biologicals*, which is available on the UMP Web site at **www.ump.hca.wa.gov**.

For the following immune globulin product CPT® codes, providers must indicate the appropriate number of units on the claim form based on the dosage indicated below:

Hepatitis B (CPT® code 90371):
1 unit for each ml used

Rabies immune globulin (CPT® codes 90375–90376):
1 unit for each ml used

Please note: Immunizations for purposes of employment, travel, immigration, licensing, or insurance are not covered under UMP. However, meningococcal vaccine is covered under the preventive care benefit for college students living in a dormitory environment, patients with chronic illness, and post-splenectomy patients.

7.7.3 Therapeutic, Prophylactic, and Diagnostic Injections and Infusions

UMP generally follows Medicare's coding guidelines and payment policies for the administration of drugs and biologicals.

CPT® code 99211 is not payable on the same date of service as a drug administration code. Other evaluation and management (E&M) codes may be reported with modifier 25 on the same date of service as a drug administration code for payment consideration only when a significant separately identifiable E&M service is provided.

When administering multiple infusions, injections, or combinations, only one "initial" service code is payable per encounter unless protocol requires that two separate IV sites must be used or the patient has to come back for a separately identifiable service on the same day. In these cases when it is necessary to report more than one initial service code, providers should report the second initial drug administration code with the modifier 59. The "initial" code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur.

If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.

The concurrent infusion CPT® code 90768 is payable only once per day.

Services such as the use of local anesthesia, IV start, access to indwelling IV (a subcutaneous catheter or port), a flush at conclusion of an infusion, standard tubing, syringes, and supplies are included in the payment for the drug administration service and are not separately payable.

Providers are required to use the specific HCPCS level II "J" or "Q" code to report the drug administered. The name, manufacturer, strength, dosage, and quantity of the drug must be documented and retained in the patient's records, and be available for review upon request.

UMP maximum allowances for covered drugs and biologicals administered by the professional provider are published in the *UMP Professional Provider Fee Schedule for Drugs and Biologicals*, which is available on the UMP Web site at **www.ump.hca.wa.gov**.

When billing for the drugs and biologicals, providers are required to follow the descriptions of the procedure codes and include the correct number of units on the claim form for appropriate coverage consideration and reimbursement.

Unclassified or unspecified HCPCS level II drug codes should be billed only when there is not a specific code available for the drug being administered. In this situation, the name, manufacturer, strength, dosage, and quantity of the drug must be included with the unclassified or unspecified drug code for coverage and payment consideration.

Please note: Codes J8499 and J8999 for oral drugs are generally not covered on UMP's fee schedule for professional providers.

7.7.4 Allergen Immunotherapy

1. When providing both the injection and antigen/antigen preparation, bill one CPT® injection code (95115 or 95117) and one of the CPT® antigen/antigen preparation codes (95145–95149, 95165, or 95170). The complete service CPT® codes (95120, 95125, and 95130–95134) are not reimbursed by UMP.
2. CPT® codes 95145–95149 and 95170 are antigen/antigen preparation codes for stinging/biting insects. All other antigen/antigen preparation services (e.g., for dust, pollens, etc.) are billed using either CPT® code 95144 for single dose vials or CPT® code 95165 for multiple dose vials.
3. CPT® code 95144 should be used only when the allergist has prepared the extract to be injected by another physician.
4. Allergists who perform the complete service using treatment boards should bill one of the antigen/antigen preparation CPT® codes (95145–95170) and a CPT® injection code (95115 or 95117).
5. Reimbursement for antigen/antigen preparation CPT® codes (95145–95149, 95165, or 95170) is per dose. If a physician injects one dose of a multiple dose vial, bill for the total number of doses in the vial and an injection code. When that physician (or another physician) injects the remaining doses at subsequent times, only the injection service should be billed.
6. Allergists billing both an injection and either CPT® code 95144 or 95165 are reimbursed the injection plus the fee for CPT® code 95165, regardless of whether CPT® code 95144 or 95165 is billed.
7. An E&M visit may be billed in addition to the allergy immunotherapy code for payment consideration only if other separately identifiable services are provided at the time. Supporting documentation for the E&M visit must be submitted to UMP upon request.

7.7.5 Chemotherapy Administration

7.7.5.1 Coding and Reimbursement for Chemotherapy Administration

UMP generally follows Medicare's coding guidelines and payment policies for payment of chemotherapy administration.

CPT® code 99211 is not payable on the same date of service as a drug administration code. Other evaluation and management (E&M) codes may be reported with modifier 25 on the same date of service as a chemotherapy drug administration code for payment consideration only when a significant separately identifiable E&M service is provided.

When administering multiple infusions, injections, or combinations, only one "initial" service code is payable per encounter unless protocol requires that two separate IV sites must be used or the patient has to come back for a separately identifiable service on the same day. In these cases when it is necessary to report more than one initial service code, providers should report the second "initial" drug administration code with the modifier 59. The "initial" code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur.

If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.

The concurrent infusion CPT® code 90768 is payable only once per day.

Services such as the use of local anesthesia, IV start, access to indwelling IV (a subcutaneous catheter or port), a flush at conclusion of an infusion, standard tubing, syringes, and supplies are included in the payment for the drug administration service and are not separately payable.

The HCPCS level II oncology demonstration project codes were established for Medicare payment purposes. They are separately payable only when UMP is paying as the secondary payer to Medicare where the services have been covered by Medicare.

7.7.5.2 Coding and Reimbursement for Chemotherapy Agents

Chemotherapy agents must be billed using the specific HCPCS level II "J" or "Q" codes. Office records must identify the name, manufacturer, strength, dosage, and quantity of the drug, and be available upon request. The *UMP Professional Provider Fee Schedule for Drugs and Biologicals* includes the allowed amounts for the chemotherapy agents, and is available on the UMP Web site at **www.ump.hca.wa.gov**.

7.7.6 Therapeutic Apheresis

Separate payment for established patient office or other outpatient visits (CPT® codes 99211–99215) and subsequent hospital care (CPT® codes 99231–99233) is not allowed on the same date that therapeutic apheresis (CPT® codes 36511–36516) is provided.

Physicians furnishing therapeutic apheresis services may bill for the appropriate E&M visit or consultation code indicating the level of services provided in lieu of billing for the therapeutic apheresis services. The time spent in apheresis management may not be counted in determining the duration of time spent on critical care services (CPT® codes 99291 and 99292).

The code for therapeutic apheresis includes payment for all medical management services provided to the patient on the same date of service. Therefore, payment is made for only one unit (of CPT® codes 36511–36516) provided by the same physician, on the same date, for the same patient.

7.7.7 End Stage Renal Disease/Dialysis Services

CPT® E&M codes 99231–99233 are not payable on the same service date as CPT® hospital inpatient dialysis codes 90935, 90937, 90945, and 90947. Payment for the E&M services is bundled into the dialysis service.

Separate billing and payment for an initial hospital visit (CPT® codes 99221–99223), an initial inpatient consultation (CPT® codes 99251–99255), or a hospital discharge service (CPT® codes 99238–99239), is allowed when billed on the same date as an inpatient dialysis service.

7.7.8 Ventilation Therapy

Separate reimbursement for ventilation management services (CPT® codes 94656, 94657, 94660, and 94662) is not allowed when an E&M service is reported on the same day. Physicians may bill either the ventilation management codes or an E&M service.

7.7.9 RU-486 Abortion Drug and Related Professional Services

The RU-486 abortion drug, administered in the provider's office, is covered by UMP. The drugs and related professional services must be submitted on the CMS-1500 claim form for payment consideration.

The maximum allowances for the drugs are determined by UMP's payment policy for drugs administered in the provider's office. Use the following HCPCS codes to report the drugs on the claim form:

S0190	Mifepristone, oral, 200mg
S0191	Misoprostol, oral, 200mcg

Note: Professional services reported under HCPCS code S0199 will not be reimbursed by UMP. Providers must bill the specific CPT® codes for the professional services provided for reimbursement consideration by UMP.

7.7.10 Miscellaneous Services

The plan provides benefits for the specialized medical services as listed below:

- Acupuncture
- Biofeedback therapy
- Blood and blood derivatives
- Bone, eye, and skin bank services
- Cardiac and pulmonary rehabilitation
- Diabetic education

- Treatment of eating disorders (bulimia, anorexia nervosa)
- PKU supplement for newborns
- Neurodevelopmental therapies
- Special nursing services
- Treatment of temporomandibular joint conditions

Please refer to the UMP *Certificates of Coverage* for details regarding scope of coverage of these benefits. For information on biofeedback therapy, refer to the UMP *Certificates of Coverage* under "Mental Health Treatment." Preauthorized biofeedback therapy for medical conditions may be covered under the medical benefit, as indicated in the UMP *Certificates of Coverage* under "Biofeedback Therapy."

7.8 Radiology Services

Covered services include x-rays and other imaging tests, studies, and examinations intended to establish a diagnosis or monitor the progress and outcome of therapy.

Diagnostic testing must be appropriate to the diagnosis or symptoms reported by the ordering physician and must be medically necessary. The ordering physician must belong to an approved provider type.

Mammograms are covered in accordance with a schedule established by UMP and published in the UMP *Certificates of Coverage*.

Positron Emission Tomography (PET) scans are subject to UMP preauthorization requirements except when there is a diagnosis of cancer.

Please refer to the UMP *Certificates of Coverage* for details regarding the scope of coverage of these benefits.

7.8.1 Separate Payment for Radiologic Contrast Material

In general, the cost of radiologic contrast material is considered bundled into the payment for the associated radiology service. Separate payment for radiologic contrast material is not made except for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and intra-arterial injections when the patient has one or more of the following characteristics (as documented in the patient's medical record):

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting;
- A history of asthma or allergy;
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;
- Generalized severe debilitation; or
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS level II procedure codes Q9945–Q9951. The brand name and dosage of the LOCM must be documented in the patient's records. The number reported in the units field on the claim form for these codes must be equal to the number of milliliters administered for appropriate reimbursement.

7.8.2 Radiopharmaceutical Diagnostic Imaging Agents

Separate payment is allowed for radiopharmaceutical diagnostic imaging agents used when performing nuclear medicine procedures.

The maximum allowed amounts for radiopharmaceutical agents are included in the *UMP Professional Provider Fee Schedule for Drugs and Biologicals*, which is available on the UMP Web site at **www.ump.hca.wa.gov**.

7.8.3 Transportation Reimbursement in Connection with Furnishing Diagnostic Tests

Payment of expenses associated with transportation of diagnostic equipment is generally included in the reimbursement for the service or procedure. Therefore, separate payment for transportation of diagnostic equipment is not allowed except for:

- Transportation of portable x-ray equipment billed under

HCPCS level II codes R0070 (one patient) or R0075 (multiple patients) in connection with services furnished by portable x-ray suppliers.
- Services billed under CPT® code 99082 (unusual travel), if a physician submits documentation to justify "very unusual travel."

Note: Portable x-ray services furnished in patients' homes are limited to the following tests:

1. Skeletal films involving extremities, pelvis, vertebral column, or skull;
2. Chest or abdominal films that do not use contrast media; and
3. Diagnostic mammograms.

7.8.4 Modifiers Required for Professional and Technical Components

The plan will reimburse for professional and technical components of radiology procedures according to Medicare payment rules. Providers must use the following modifiers, as appropriate, when billing radiology services.

26	**Professional Component** This modifier is used to bill for the professional component of a procedure which can be split into professional and technical components.
TC	**Technical Component** This modifier is used to bill for the technical component of a procedure which can be split into professional and technical components.

UMP recognizes that some providers may use modifiers 26 and/or TC to separately report the professional and/or technical components of a service when the global service was provided. In these instances, UMP's combined payment for the separate components will not exceed the fee schedule amount for the global procedure.
If another provider (for example, a facility) performs the technical component of a service, the provider performing only the professional component must report his/her service using the 26 modifier to signify that he/she performed only the professional component of the service.

The reverse is true in instances where another provider performs the professional component; in this case, the provider performing only the technical component must report the service using the TC modifier to signify that only the technical component of the service was performed.

7.9 Laboratory Services

Covered services include diagnostic laboratory tests, studies, and examinations intended to establish a diagnosis or monitor the progress and outcome of therapy.

Diagnostic testing must be appropriate to the diagnosis or symptoms reported by the ordering physician and must be medically necessary. The ordering physician must be an approved provider. If the clinician refers lab tests to an outside vendor for processing, the diagnosis(es) must accompany the referral.

Please refer to the UMP *Certificates of Coverage* for details regarding scope of coverage of these benefits.

7.9.1 Payment for Laboratory Services

The following laboratory services are reimbursed based on the relative value units established in the Medicare Physician Fee Schedule Data Base:

- Clinical pathology consultations
- Bone marrow services
- Physician blood bank services
- Cytopathology services
- Surgical pathology services

UMP fee schedule amounts for laboratory services not identified above are based on the Medicare Clinical Laboratory Fee Schedule.

7.9.2 Modifiers Required for Professional and Technical Components

The plan will reimburse for professional and technical components of laboratory services according to Medicare payment rules. Providers must use the following modifiers, as appropriate, when billing laboratory services:

26	**Professional Component** This modifier is used to bill for the professional component of a procedure which can be split into professional and technical components.
TC	**Technical Component** This modifier is used to bill for the technical component of a procedure which can be split into professional and technical components.

UMP recognizes that some providers may use modifiers 26 and/or TC to separately report the professional and/or technical components of a service when the global service was provided. In these instances, UMP's combined payment for the separate components will not exceed the fee schedule amount for the global procedure.

If another provider (for example, a facility) performs the technical component of a service, the provider performing the professional component must report his/her service using the 26 modifier to signify that he/she performed only the professional component of the service.

The reverse is true in instances where another provider performs the professional component; in this case, the provider performing the technical component must report the service using the TC modifier to signify that only the technical component of the service was performed.

7.9.3 Stat Laboratory Services

Usual laboratory services are covered under the UMP fee schedule. In cases where laboratory tests are appropriately performed on a "stat" basis, the provider may bill the applicable HCPCS level II code S3600 or S3601 for payment consideration. Reimbursement is limited to one stat charge per episode (not one per test). Tests ordered stat are limited to only those that are needed to manage the patient in a true emergency situation. The laboratory report must contain the name of the provider who ordered the stat test(s). The medical record must reflect the medical necessity and urgency of the service.

The stat charge will be paid only with the tests listed on the following two pages. Please refer to a CPT® book for complete code descriptions.

The UMP Billing & Administrative Manual contains abbreviated definitions of procedure codes. For billing purposes, please refer to the most current edition of the CPT® and HCPCS books for complete descriptions of the procedure codes.

Stat Laboratory Tests

CPT® Code	Brief Description
80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen
80101	Drug screen
80156	Assay of carbamazepine
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay of primidone
80192	Assay of procainamide

Stat Laboratory Tests

CPT® Code	Brief Description
80194	Assay of quinidine
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/ scope
81001	Urinalysis, auto w/ scope
81002	Urinalysis nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urinalysis
82003	Assay of acetaminophen
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin, total
82248	Bilirubin, direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine
82803	Blood gases: pH, pO_2 & pCO_2
82945	Glucose other fluid
82947	Assay quantitative, glucose
83615	Lactate (LD) (LDH) enzyme
83663	Fluoro polarize, fetal lung
83664	Lamellar bdy, fetal lung
83735	Assay of magnesium
83874	Assay of myoglobin
83880	Natriutetic peptide
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84157	Assay of protein, other
84295	Assay of serum sodium
84302	Assay of sweat sodium
84450	Transferase (AST) (SGOT)
84484	Assay of troponin, quant

Stat Laboratory Tests

CPT® Code	Brief Description
84512	Assay of troponin, qual
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
85004	Automated diff wbc count
85007	Differential WBC count
85025	Automated hemogram
85027	Automated hemogram
85032	Manual cell count, each
85046	Reticyte/hgb concentrate
85049	Automated platelet count
85378	Fibrin degradation
85380	Fibrin degradation, vte
85384	Fibrinogen
85396	Clotting assay, whole blood
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86367	Stem cells, total count
86403	Particle agglutination test
86849	Immunology procedure
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86923	Compatibility test, electric
86971	RBC pretreatment
87205	Smear, stain & interpret
87210	Smear, stain & interpret
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia
87400	Influenza a/b, ag, eia
88400	Bilirubin total transcut
89051	Body fluid cell count
G0306	CBC/diffwbc w/o platelets
G0307	CBC without platelet

7.10

Anesthesia Services

Services covered under this benefit include anesthesia services related to medically necessary surgery or pain management for a covered condition. Please refer to the UMP *Certificates of Coverage* for details regarding scope of coverage of these benefits.

7.10.1 Anesthesia Payment System Overview

The Anesthesia Payment System was developed and adopted by the following three Washington State agencies:

- The **Health Care Authority (HCA)**–The state agency that administers UMP for public employees and retirees.
- The **Department of Labor and Industries (L&I)**–The state agency that administers the state's workers' compensation program (State Fund Industrial Program only).
- The **Health and Recovery Services Administration (HRSA)**, within the **Department of Social and Health Services (DSHS)**–The state agency that administers the state's Medicaid program.

The Reimbursement Steering Committee (RSC), consisting of members from the three state agencies, develops, maintains, and updates the anesthesia fee schedules and approves payment policies. The State Agency Anesthesia Technical Advisory Group (ATAG), which represents anesthesiologists, certified registered nurse anesthetists (CRNAs), and billing professionals, advises the RSC on anesthesia payment policies and reimbursement.

Anesthesia services are reimbursed according to actual time units and anesthesia base units. For the majority of the CPT® anesthesia codes, the anesthesia bases in the UMP payment system are the same as the anesthesia base units adopted by both Medicare and the American Society of Anesthesiologists (ASA). For the CPT® anesthesia codes where Medicare and the ASA bases are different, Medicare's anesthesia bases are used, with a few exceptions. Payment for some procedures, including pain management services, intubation, Swan-Ganz insertion and placement, and selected surgical services, is based on the UMP *Professional Provider Fee Schedule* amounts.

7.10.2 Anesthesia Procedure Codes

Anesthesia services paid according to base and time units must be billed with CPT® anesthesia codes 00100 through 01999 with the applicable anesthesia modifier. Refer to Section 7.10.3 for the appropriate modifiers. The anesthesia procedure codes should be selected according to the descriptions published in CPT®.

7.10.3 Anesthesia Modifiers

Providers must report the applicable anesthesia modifier from the table below with the appropriate anesthesia procedure code for payment consideration. UMP accepts all valid CPT®/HCPCS modifiers; however, the modifiers identified in the table are the only ones that affect payment for the anesthesia services.

	Physician Performing
AA	Anesthesia service performed personally by anesthesiologist
	Physician Directing
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QY	Medical direction of one CRNA by an anesthesiologist
	Physician Supervising
AD	Medical supervision by a physician
	CRNA Performing
QX	CRNA service with medical direction by a physician
QZ	CRNA service without medical direction by a physician

Please note: Special instructions for the above-referenced modifiers:

1. **Medical direction of anesthesia modifiers (QK and QY).**

   UMP follows Medicare's payment policy for medical direction of anesthesia services. For each

patient, the physician is required to:

- Perform a pre-anesthetic examination and evaluation;
- Prescribe the anesthesia plan;
- Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;
- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions;
- Monitor the course of anesthesia administration at frequent intervals;
- Remain physically present and available for immediate diagnosis and treatment of emergencies; and
- Provide indicated post-anesthesia care.

In addition, the physician may direct no more than four anesthesia services concurrently and may not perform any other services while directing the single or concurrent services. The physician may attend to medical emergencies and perform other limited services (as Medicare allows) and still be deemed to have medically directed anesthesia procedures. The physician is required to document in the patient's medical record that the medical direction requirements identified above were met.

2. **Monitored anesthesia care service.** Monitored anesthesia care is reimbursed in the same way as regular anesthesia care, but instead of using the QS modifier, services should be billed in the following manner:
   - If the physician personally performs the services, bill modifier AA.
   - If the physician directs four or fewer concurrent procedures and monitored care represents two or more of the procedures, bill modifier QK.
   - If the CRNA personally performs all of the service, bill modifier QZ.
   - If the CRNA is medically directed, bill modifier QX.
3. **Teaching anesthesia services.** Modifier AA is recognized on an anesthesiologist's claim in a teaching situation (as long as UMP does not receive a separate claim for professional anesthesia services from any other provider).

7.10.4 Anesthesia Time Units

The anesthesia payment system is based on a per-minute reporting system. Providers must report the actual anesthesia minutes rounded to the next whole minute in the units field (24G) on the CMS-1500 claim form. UMP will apply the specific base units for the particular procedure code being billed.

Anesthesia time begins when the provider starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).

Following Medicare's payment policy, providers may sum up blocks of time around a break in continuous anesthesia care, as long as there is continuous monitoring of the patient within the blocks of time. This policy does not alter the fundamental principle that anesthesia time represents a continuous block of time when a patient is under the care of an anesthesiologist or CRNA. Billing of time units for the pre-anesthesia exam and evaluation is not allowed as these services are included in the base unit component.

7.10.5 Add-on Anesthesia Procedure Codes

7.10.5.1 Burn Excisions or Debridement

Providers may report the CPT® anesthesia add-on code 01953 in addition to the primary anesthesia code 01952 when it is appropriate for payment consideration. In such a situation involving anesthesia for second- and third-degree burn excision or debridement, the total anesthesia minutes are reported in the units field (24G) with the primary anesthesia code 01952. The units field (24G) on the claim form for the add-on code 01953 must represent one unit for each additional 9% total body surface area or part thereof. (Refer to the CPT® book for the complete descriptions of procedure codes.)

7.10.5.2 Obstetric

The CPT® anesthesia add-on codes 01968 (Cesarean delivery following neuraxial labor analgesia/anesthesia) and 01969 (Cesarean hysterectomy following neuraxial labor analgesia/anesthesia) may be reported in conjunction with CPT® anesthesia code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery) when it is appropriate for payment consideration. In these obstetric situations, the anesthesia time for the primary and add-on procedures are reported and paid separately.

7.10.6 Anesthesia Maximum Allowance

The UMP maximum allowance for payment of anesthesia services is determined as follows:

Step	Maximum Allowance Calculation
1	Multiply anesthesia base units by 15
2	Add total billed minutes to value from step 1
3	Multiply total from step 2 by UMP's per-minute conversion factor*

**In UMP's claims system, the 15-minute conversion factor is translated into an equivalent per minute conversion factor (for example, a conversion factor of $46.70 converts to $3.1133 per minute)*

Sample calculation

Billed time from provider	= 120 minutes
UMP anesthesia base units	= 5 units
UMP maximum allowance	= (base x 15 + billed time) x per minute conversion factor
	= (5 x 15 + 120) x $3.1133
	= **$607.09**

Note: If an anesthesiologist or CRNA personally performs the anesthesia service, UMP reimbursement is based on 100 percent of the maximum allowed charge. In a team care situation, where an anesthesiologist medically supervises or medically directs the CRNA services, reimbursement to the anesthesiologist and CRNA is based on 50 percent of the total maximum allowance.

7.10.7 Anesthesia Payment Limitations for Obstetric Deliveries

A maximum time of six hours (360 minutes) per obstetric delivery is allowed for epidural anesthesia.

7.10.8 Pain Management and Other Services Paid Under the RBRVS Methodology

Some procedures commonly performed by anesthesiologists and CRNAs are reimbursed using the RBRVS maximum allowance, instead of anesthesia base and time units. These services include most pain management services, intubation, Swan-Ganz insertion and placement, as well as other selected surgical services. Providers should bill the applicable CPT® surgery or medicine codes (with no anesthesia modifier) for reimbursement consideration. Refer to the *UMP Anesthesia Fee Schedule* for the RBRVS maximum allowances for these services.

7.10.9 Anesthesia Services Performed by the Surgeon (CPT® modifier 47) Payment Policy

Separate reimbursement for local, regional, digital block, or general anesthesia administered by the surgeon is not allowed by UMP. Based on Medicare's policy, these services are not separately payable, as they are considered in the RBRVS maximum allowance for the procedure.

7.10.10 Acupuncture Services

Acupuncture performed by a physician for anesthesia or pain management should be reported with the applicable CPT® acupuncture treatment codes for payment consideration.

See the UMP *Certificates of Coverage* for scope of coverage information and benefit limits.

7.11

Therapy Services

7.11.1 Physical, Occupational, Speech, and Massage Therapy Services

A current prescription with an up-to-date plan of treatment is required to be on file in the provider's office and be available upon request. When billing for therapy services, the prescribing provider's complete name and credential must be included in box 17 of the claim form for payment consideration. UMP does not cover self-prescribed physical, occupational, speech, or massage therapy. Please refer to the UMP *Certificates of Coverage* for details regarding scope of coverage and benefit limits.

7.11.1.1 Billing and Payment Rules for Physical Therapy Services

1. Physical therapy initial evaluation: CPT® code 97001 is to be used to report the initial evaluation before the plan of care is established. This evaluation is for the purpose of evaluating the patient's condition and establishing the plan of care.
2. Physical therapy periodic re-evaluation: CPT® code 97002 is to be used for reporting the re-evaluation of a patient who has been under an established plan of care. This evaluation is for the purpose of evaluating the patient's condition and revising the patient's plan of care.
3. Physical therapists must bill the appropriate CPT® physical medicine and rehabilitation codes (97010–97750 and 97799) for specific modalities and procedures.
4. CPT® evaluation and management codes (99201–99350) are not payable when billed by a physical therapist.

7.11.1.2 Billing and Payment Rules for Occupational Therapy

1. Occupational therapy initial evaluations: CPT® code 97003 is to be used to report the initial occupational therapy evaluation before the plan of care is established by the occupational therapist (OT) or physician. This evaluation is for the purpose of evaluating the patient's condition and establishing the plan of care.
2. Occupational therapy re-evaluation: CPT® code 97004 is to be used to report the re-evaluation of a patient who has been under a plan of care established by an OT or a physician. This evaluation is for the purpose of evaluating the patient's condition and revising the plan of care under which the patient is being treated.
3. Occupational therapists must bill the appropriate codes within the physical medicine and rehabilitation section of CPT®.
4. CPT® evaluation and management codes 99201–99350 are not payable when billed by an occupational therapist.

7.11.1.3 Billing and Payment Rules for Speech Therapy Services

1. Speech therapy services should be reported with the applicable CPT® codes.
2. Please note that only one unit should be reported with CPT® codes 92506–92508 per day, regardless of the duration of the time for the visit. If multiple units are reported, payment will be capped at 1 unit.

7.11.1.4 Billing and Payment Rules for Massage Therapy

1. Massage therapy services should be reported with the applicable CPT® code.
2. Massage therapy services exceeding one hour will not be covered unless preauthorized.

7.12

Osteopathic Services

7.12.1 Payment Rules for Osteopathic Manipulation Therapy (OMT) (CPT® Codes 98925–98929)

- UMP reimburses an evaluation and management (E&M) procedure code in addition to an OMT procedure code only if the patient's condition requires a significant, separately identifiable E&M service above and beyond the usual pre- and post-service work associated with the procedure. The physician must bill the E&M procedure code with a modifier 25 and the level of E&M service billed must be supported by documentation in the patient's record. The supporting documentation must be provided to UMP upon request.
- Manipulations of the spine or extremities, or office calls in which such manipulations are performed (which includes CPT® codes 98925–98929), are limited to a combined total of 10 per calendar year. See Section 7.13.3 for UMP payment policy on complementary and preparatory services.

7.13

Chiropractic Services

Manipulations of the spine or extremities, or office visits in which such manipulations are performed, are limited to a combined total of 10 visits per calendar year. Please refer to the UMP *Certificates of Coverage* for details regarding scope of coverage of these benefits.

7.13.1 Chiropractic Manipulative Treatment (CPT® Codes 98940–98943)

The CPT® codes and definitions must be followed when billing UMP for manipulations of the spine or extremities. Depending on the number of spinal regions treated, report CPT® code 98940, 98941, or 98942 as indicated in the CPT® book. When manipulation of the extremities is performed, CPT® code 98943 may be separately reported for payment consideration.

Note: UMP does not recognize multiple units on the claim form for any of the chiropractic manipulation codes.

Multiple procedure rules apply when manipulations of the spine and extremities are reported on the same date of service. The maximum allowance for the extremity manipulation code will be reduced to 50 percent in this circumstance. In billing multiple procedures, modifier 51 must be reported with the extremity manipulation code on the claim form.

The chiropractic manipulative treatment codes 98940–98943 include a premanipulation patient assessment.

7.13.2 Payment Rules for Separate Reporting of Evaluation and Management Services and Other Chiropractic Services

UMP follows the CPT® book definitions for E&M services for new and established patients. If a provider has treated a patient for any reason within the last three years, the person is considered an established patient. (Refer to the CPT® book for complete code descriptions, definitions, and guidelines.)

Chiropractic physicians may report the first four levels of CPT® new patient office visits codes 99201–99204 and the first four levels of CPT® established patient office visit codes 99211–99214 when appropriate for UMP payment consideration.

7.13.2.1 New Patient E&M Services (CPT® codes 99201–99204)

A new patient E&M office visit code is payable only once within a three-year period, regardless of whether the services are billed with modifier 22. New patient E&M office visit codes are payable with manipulation codes only when all of the following conditions are met:

- The E&M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included in the manipulation visit;
- Modifier 25 is added to the new patient E&M code; and
- Supporting documentation describing the service(s) provided is available in the patient's record.

7.13.2.2 Established Patient E&M Services (CPT® codes 99211–99214)

An established patient E&M office visit code is not payable on the same day as a new patient E&M office visit code regardless of whether the services are billed with modifier 22. Established patient E&M codes are not payable in addition to manipulation codes for follow-up visits except when all of the following conditions are met:

- The E&M service is for the initial visit for a new condition or new injury;
- The E&M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included in the manipulation visit;
- Modifier 25 is added to the E&M code; and
- Supporting documentation describing the service(s) provided is available in the patient's record.

When a patient requires re-evaluation for an existing condition or injury, either an established patient E&M CPT® code (99211–99214) or a chiropractic manipulation CPT® code (98940–98943) is payable. Payment will not be made for both. Modifier 25 is not applicable in this situation.

Supporting documentation for separate reporting of evaluation and management services must be provided to UMP upon request.

7.13.3 Complementary and Preparatory Services

Patient education or complementary and preparatory services are not separately reimbursed. Complementary and preparatory services are defined by UMP as interventions that are used to prepare a body region for or facilitate a response to a spinal or extremity manipulation/adjustment. For example, the application of heat or cold and pre-manipulation exercise programs are considered complementary and preparatory services that are not separately payable.

7.14 Podiatry Services

Routine foot care procedures, corrective shoes, treatment of fallen arches or symptomatic complaints of the feet, orthotics, and prescriptions thereof, and routine hygienic care of the feet are not covered by UMP. UMP covers foot care appliances for prevention of complications associated with diabetes. Other services rendered by a podiatric physician are covered in accordance with the plan benefits. Please refer to the UMP *Certificates of Coverage* for details regarding scope of coverage of these benefits.

7.15 Vision Services

Coverage and payment limitations for routine eye examinations and the purchase of lenses, frames, and contact lenses, and payment for implant lenses in connection with cataract surgery or surgery for a missing portion of the eye, are described in the UMP *Certificates of Coverage*.

Please note: The limitations for vision hardware listed in the *Certificates of Coverage* are benefit limitations, not fee schedule limitations. Providers may bill the enrollee for the difference between the benefit limitation for vision hardware and the provider's billed charges.

7.16

Dental Services

Routine and preventive dental services, orthognathic surgery, dental implants, and nonsurgical treatment of TMJ are not covered under the plan, but may be covered under a PEBB dental plan. Under UMP, services of dentists are covered only for specific surgical treatments and treatment of certain injuries. Please refer to the UMP *Certificates of Coverage* for details regarding scope of coverage of these benefits.

7.17

Prescription Drugs

UMP offers a prescription drug benefit through both a retail and a mail-order pharmacy benefit manager (PBM). Both are administered by Express Scripts, Inc. Most pharmacies in Washington State are preferred with the UMP network. General questions related to mail-order or retail prescriptions can be answered by calling Express Scripts at 1-866-576-3862. Providers may call in prescriptions to 1-800-763-5502, or fax to 1-800-396-2171. Faxing on provider letterhead is required to confirm the validity of the prescription(s) and will expedite processing.

For drugs requiring coverage review or preauthorization, please call Express Scripts at 1-800-417-8164. Be prepared to provide the patient's name, date of birth, UMP I.D. number, and some brief clinical information that would show the medical necessity for these drugs. If you prefer to fax preauthorization requests to Express Scripts, the request with the pertinent information should be faxed to 1-877-697-7192.

UMP network pharmacies offer a discounted rate to UMP enrollees. Enrollee out-of-pocket expenses are much less if generic drugs are purchased. Network pharmacies will handle all claims submission for the enrollee, and once the annual prescription drug deductible has been met, the enrollee is responsible only for the applicable coinsurance at the network pharmacy point of sale.

UMP offers a three-tier prescription drug benefit design. UMP enrollees will save money when prescriptions are dispensed according to the *UMP Preferred Drug List* (PDL). The UMP PDL includes drugs from the Washington State Preferred Drug List and drugs from Express Scripts National Preferred Formulary. This PDL is updated quarterly and is available on the UMP Web site.

Please note: UMP has implemented the Therapeutic Interchange Program (TIP), based upon the Washington Preferred Drug List. Under TIP, once a prescribing provider has endorsed the PDL, any Washington State retail pharmacist who fills a prescription for a UMP enrollee will usually replace any nonpreferred medication with a less-expensive, preferred medication when that prescription is filled at a retail pharmacy in Washington State. If the provider or patient does not want the substitution made, the provider should sign the prescription "dispense as written," or the enrollee can specifically ask the pharmacist to dispense the nonpreferred drug. However, the enrollee will pay the higher Tier 3 cost-share if they receive a nonpreferred brand name drug.

If the prescribing provider has not endorsed the PDL, the pharmacist is not allowed to make the substitution, unless it is for a generic equivalent and the provider has allowed substitution. To find out more about endorsing the PDL, providers should visit the Prescription Drug Program's Web site at **www.rx.wa.gov**.

UMP has changed how it covers specialty drugs. Prescriptions for specialty drugs are limited to a 30-day supply per prescription/refill. The initial fill for a given specialty drug prescription may be obtained from a retail pharmacy; however, all subsequent fills must be through UMP's specialty drug vendor, CuraScript. To order a specialty drug from CuraScript, either the patient or the provider should call CuraScript at 1-866-413-4135. If the patient initiates the order, the CuraScript pharmacy team will contact the physician to obtain a prescription and confirm the order. Most specialty drugs are covered under Tier 1. However, if a brand-name specialty drug has a generic equivalent available, it is covered

as nonpreferred (Tier 3). Switching to a generic when feasible could save your patients a lot of money. For more information on specialty drug coverage, see the *UMP 2006 Certificates of Coverage*.

Specific information on the UMP's PDL and Drug Utilization Program is available on the UMP Web site at **www.ump.hca.wa.gov** or by contacting Express Scripts at 1-866-576-3862.

Please refer to the UMP *Certificates of Coverage*, "Prescription Drugs" section, for benefit exclusions and a description of drugs that are covered under the plan.

7.18

Tobacco Cessation Services

UMP covers services to assist enrollees in withdrawing from tobacco dependence through the *Free & Clear* tobacco cessation program. This is the only tobacco cessation program covered by UMP. Please refer to the UMP *Certificates of Coverage* for details regarding scope of coverage of these benefits. For information regarding the *Free & Clear* tobacco cessation program, call 1-800-292-2336.

7.19

Telemedicine Services

UMP covers certain telemedicine services. This provisional policy was adopted as a pilot, to help ensure that enrollees in rural areas have access to specialist consultations and similar services. The patient must be present and participating in the telehealth visit. A medical professional is not required to present the patient to the specialist unless it is medically necessary, as determined by the specialist at the distant site.

UMP considers "telehealth" to be the use of interactive real-time audio and video telecommunications to deliver medically necessary covered services to a patient at a site other than where the specialist is located. In these situations, the use of a telecommunications system may substitute for a face-to-face, "hands-on" encounter. The provider and patient are able to interact as if they were having a face-to-face session, without the patient having to travel long distances.

UMP follows Medicare's policy for coverage and payment of telehealth services with a few exceptions. To be eligible for UMP coverage:

- The telehealth services must be medically necessary.
- Interactive audio and video telecommunications must be used, permitting real-time communication between the distant site practitioner (specialist) and patient.
- The referring provider for telemedicine consults must be a UMP-approved provider type.
- The originating site must be located in a rural health provider specialty shortage area and be one of the following:
  - Provider's office;
  - Community mental health center/Regional Support Network (RSN);
  - Hospital;
  - Rural health clinic; or
  - Federally qualified health center.
- The specialist performing the telehealth services at the distant site must be a UMP network provider and be:
  - A physician in a specialty not available in the community where the patient lives; or
  - A psychologist; or
  - A speech pathologist.

Telemedicine technology and services not covered by UMP include:

- "Store and Forward" technology (i.e., asynchronous transmission of medical information reviewed at a later time by physician or practitioner at distant site);
- E-mail, telephone, and facsimile transmissions;
- Installation or maintenance of any telecommunication devices or systems;
- Home health monitoring;
- HCPCS code T1014 (telehealth transmission, per minute); and
- CPT® code 0074T (online medical evaluation, per encounter, using Internet or similar electronic communications network in response to a patient's request).

7.19.1 Telehealth Billing and Reimbursement Information

Originating site (patient's location)
Providers seeking reimbursement for the originating site facility fee should report HCPCS procedure code Q3014. Hospitals should follow Medicare's coding rules, which include reporting the applicable revenue code for the department where the telemedicine was performed (HCPCS procedure code Q3014). UMP's fee schedule amount for HCPCS code Q3014 is based on Medicare's fee schedule amount.

A charge for a professional service is reimbursable only if a separately identifiable medically necessary professional service is provided on the same day as the telehealth service. Documentation for both services must be clearly and separately identified in the medical record. Payment of covered professional services will be based on the *UMP Professional Provider Fee Schedule* amounts.

Distant site (specialist's location)
Specialist services eligible for coverage are limited to:

- Consultations (CPT® codes 99241-99255);
- Diabetes outpatient self-management training sessions (HCPCS codes G0108-G0109) if delivered by a Medicare-approved diabetes education program and otherwise covered under the UMP diabetic education benefit;
- End Stage Renal Dialysis (ESRD) Services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, G0318);
- Individual psychotherapy (CPT® codes 90804-90809);
- Medical nutrition therapy (G0270–G0271, and 97802–97804)
- Office or other outpatient visits (CPT® codes 99201-99215);
- Pharmacologic management (CPT® codes 90862);
- Psychiatric intake and assessment (CPT® code 90801);
- Speech and audiologist services (CPT® codes 92541-92548, 92551-92588, 92597).

The specialists must report modifier GT with the applicable procedure code to indicate the telehealth service was provided via interactive audio and video telecommunications. UMP allowed amount for the covered professional service is the *UMP Professional Provider Fee Schedule* amount for the same service provided without the use of telecommunications.

7.20 Outpatient Diabetic Education Program Services

UMP follows Medicare coding guidelines and payment polices for coverage of outpatient diabetic education services. Services provided under an approved outpatient diabetic education program (including diabetic education services provided by dieticians/nutrition therapists) should be reported with the applicable CPT®/HCPCS procedure code for payment consideration.

Dieticians may bill UMP for diabetic self-management training (DSMT) services performed in collaboration with a Medicare-approved outpatient diabetes education program. In these situations, the dietician is part of a multi-disciplinary team providing DSMT services for the program. This includes situations where dieticians in rural areas are the sole provider of the DSMT services. The DSMT must be billed with HCPCS code G0108 or G0109 for payment consideration. Following the CPT® code definition, the appropriate number of units should be included in the units field on the claim form.

These services may also be provided through covered telemedicine technology. When the DSMT has been provided through telemedicine technology, modifier GT should be reported with the code.

UMP allows a combined total of 10 hours annually for diabetic education services reported under HCPCS codes G0108 or G0109.

UMP will not pay for diabetic self-management training and medical nutrition therapy on the same date of service.

7.21

Medical Nutrition Therapy Services

UMP follows Medicare coding guidelines and payment polices for medical nutrition therapy (MNT). The MNT must be billed with the applicable CPT® codes 97802-97804 or HCPCS codes G0270-G0271 for payment consideration. Following the CPT® code definition, the appropriate number of units should be included in the units field on the claim form.

Note that CPT® code 97802 is payable only for an initial MNT visit. CPT® code 97803 must be used for all individual reassessments and all interventions after the initial visit. CPT® code 97804 is used for all MNT group visits, initial and subsequent. UMP allows up to 3 hours of MNT in the initial year (with 2 hours of follow-up in subsequent years). UMP will consider allowing additional hours of MNT if there is a change in the medical condition, diagnosis, or treatment regimen.

The applicable HCPCS codes (G0270 and G0271) should be used for MNT reassessment and subsequent intervention(s) following second referral in the same year for a change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease).

UMP will not pay for diabetic self-management training and medical nutrition therapy on the same date of service.

MNT services may be provided through covered telemedicine technology. When MNT has been provided through telemedicine technology, modifier GT should be reported with the procedure code.

Section 8

Provider Inquiries, Complaints, Reconsideration Procedures, and Dispute Resolutions

Please note: *The section below applies specifically to provider concerns. There is a separate appeals process for enrollees seeking a change in UMP coverage or benefit determinations. Complaints and appeals on behalf of enrollees should be addressed under that process, which is described in detail in the UMP* Certificates of Coverage.

Questions? Call 425-686-1246 or 1-800-464-0967.

8.1

Provider Inquiry, Complaint, Reconsideration Procedures, and Dispute Resolutions

UMP has specific procedures for provider inquiries, complaints, and claim reconsideration requests. Definitions for each of these and the procedures follow.

8.1.1 Inquiry

A request for information or for an explanation.

If you have an inquiry such as a question on claims payment status, plan benefits, or enrollee eligibility, please call UMP Provider Services at 425-686-1246 or 1-800-464-0967. In most cases, your question will be answered right away.

8.1.2 Complaint

An expression of dissatisfaction submitted on behalf of a provider regarding:

- Coverage or payment for health care services; or
- UMP policies or practices.

To register a complaint, you may also contact UMP Provider Services at the above numbers; fax the complaint to 425-670-3197; or write to:

Uniform Medical Plan
(or UMP Neighborhood)
P.O. Box 34578
Seattle, WA 98124-1578

Most complaints will be resolved immediately or within one business day of receipt. However, for more complex issues, the turnaround time for reviewing and responding to provider complaints may be up to 30 calendar days.

8.1.3 Reconsideration

Reevaluation of a previous decision by UMP in response to a provider's written request. The request may be in reference to:

- An adverse decision regarding a complaint;
- An unresolved claims processing issue;
- Decision to deny, modify, reduce, or terminate payment, coverage, or preauthorization for health care services or benefits. (Note that issues raised specifically on behalf of an enrollee or at the direction of an enrollee follow a separate appeals process described in the UMP *Certificates of Coverage*, and are not considered provider reconsiderations.)

Issues specifically relating to provider contract provisions, credentialing criteria for network participation, and approved provider types are also handled through a process that is separate from provider reconsideration requests (see Section 8.2).

There are two levels of provider reconsiderations:

Level 1: Within 180 days of receiving the notice of action leading to the request, submit your request for reconsideration to:

Uniform Medical Plan
(or UMP Neighborhood)
First-Level Provider Reconsideration
P.O. Box 34578
Seattle, WA 98124-1578

Please include the date of service and indicate clearly the issues that you wish to be reconsidered. Your request will be assigned to the appropriate experienced UMP staff, depending on the issue.

Most requests are completed within 30 calendar days of the date UMP received your request for reconsideration. If the decision is to reprocess the claim, you will receive a Detail of Remittance as notification. Otherwise, you will receive a written response.

Level 2: If you do not agree with the decision at Level 1 of the reconsideration process, you may submit a request for further reconsideration to:

Uniform Medical Plan
(or UMP Neighborhood)
Provider Relations Committee
Second-Level Provider Reconsideration
P.O. Box 34578
Seattle, WA 98124-1578

Requests for Level 2 reviews must be submitted within 60 calendar days of the date of the Level 1 determination. Include all of the information that was reviewed through the Level 1 reconsideration process, a copy of the Level 1 determination, and any other information or documentation you think may be helpful. Your request for a Level 2 reconsideration will be reviewed by our Provider Relations Committee. Most decisions will be made within 30 calendar days from receipt of your request for reconsideration.

Please note: There are no further reconsideration processes available through UMP for non-network providers. The Level 2 reconsideration process is the final decision of UMP.

If you are a network provider and are not satisfied with the outcome of the second level determination, you may request a dispute hearing with the Administrator of the Health Care Authority (HCA), using the dispute resolution procedure described below.

8.1.4 Dispute Resolution

A network provider may request a dispute hearing with the Administrator of the HCA. Instead of handling the issue personally, the Administrator of the HCA may designate someone to act on his or her behalf, following the same procedures and with the same effect as described below.

These dispute resolution procedures are not offered to non-network providers. Also, they do not apply to issues raised on behalf of enrollees (see the current UMP *Certificates of Coverage* for enrollee appeals procedures). Also, these procedures do not apply to contract terminations or credentialing decisions (see Section 8.2). Disputes will be resolved as quickly as possible.

A. The request for a dispute hearing must:

   - Be in writing and signed by either the provider requesting the hearing or the provider's representative;
   - State the disputed issue(s);
   - Identify the pertinent contract provision(s);
   - State the provider's position on the issues;
   - Confirm that all other contractually available procedures for resolving the issue have been exhausted;
   - Include the name and address of the provider, as well as the name of any person acting on the provider's behalf in the matter of the hearing; and
   - Be mailed within 30 days of the date of the letter with UMP's second-level decision to:

     Uniform Medical Plan
     (or UMP Neighborhood)
     Provider Dispute Hearing Request
     P.O. Box 91118
     Seattle, WA 98111-9218

B. The UMP Director of Operations may provide a written statement setting forth UMP's position and reasoning, and including any information that may be helpful. Any statement by UMP on the dispute must be mailed to the Administrator and the provider within 20 working days after receipt of the provider's statement.

C. The Administrator shall review the written statements and reply in writing to the provider and UMP Director of Operations within 30 working days. The Administrator may extend this period by notifying all parties.

Both UMP and the provider will continue without delay to carry out all their respective responsibilities as defined by contract.

8.2

Provider Contract or Network Issues

Inquiries, complaints, or disputes concerning the following issues should be directed to the UMP Provider Services Manager:

- Provider contract provisions;
- Credentialing criteria for network participation;
- Approved provider types.

Correspondence regarding these issues may be sent to:

Uniform Medical Plan
(or UMP Neighborhood)
Provider Services Manager
P.O. Box 91118
Seattle, WA 98111-9218

Uniform
Medical Plan
Your Health, Your Plan Your Choice

Explanation of Benefits

01/06/2006

If you have questions, contact us:

By Mail:
Uniform Medical Plan
PO Box 34578
Seattle, WA 98124-1578

By Phone/E-mail:
Local: 425-670-3000
Toll Free: 1-800-762-6004
E-mail: www.ump.hca.wa.gov

Your UMP ID Number: W999999999
Subscriber Name: UMP MEMBER
Patient Name UMP DEPENDENT
Claim Number: 999999999-00

UMP MEMBER
PO BOX 999
SEATTLE WA 98124

Provider Information

PHYSCIAN MD
999 VILLAGE PLAZA
SEATTLE WA 98124

Provider Name:	Date(s) of Service	Service(s) Provided	Amount Charged	UMP Allowed	PPO Savings	Non-Cov'd Amount	Deductible	Copay	Co-Ins. %	UMP Paid	Patient's Responsibility	See Notes Section
PHYSCIAN MD	01/03/06 - 01/03/06	99213 OFFICE/HOME/CLINIC VISIT	85.00	70.00	15.00				90	63.00	7.00	
		TOTALS	**85.00**	**70.00**	**15.00**	**0.00**				**63.00**	**7.00**	

Other Insurance Paid Amount	**0.00**
(*) See Notes Adjustment	**0.00**
UMP Final Paid Amount/Check	**63.00** # 999999

Total Payment to Provider: ******63.00 **Total Payment to Enrollee:** ********0.00

NOTES:

THANK YOU FOR USING A UNIFORM MEDICAL PLAN
PARTICIPATING PROVIDER

DEDUCTIBLE

YOU HAVE MET 200.00 OF YOUR 200.00 DEDUCTIBLE FOR 01/01/2006 - 12/31/2006

GENERAL INFORMATION:

APPEALS PROCESS

If you disagree with any claims decisions on this notice, call the phone numbers listed under "Contact us."
Most problems can be resolved by phone. However, if you cannot resolve the problem at that level, you can request an appeal within 12 months of this notification. Following the instructions below.

1. Circle the items you disagree with and attach an explanation of why you disagree.
2. Send this information to:

   Uniform Medical Plan
   First Level Appeals
   PO Box 34578
   Seattle, WA 98124-1578
3. Keep a copy of this Explanation of Benefits for your records.
4. Sign here: _____ Daytime Phone Number: ( ) ____-_____

200601060217 TE

ENV 1

L1561020164

UNIFORM MEDICAL PLAN
P O BOX 34850
SEATTLE WA 98124-1850
Toll Free: 1-800-464-0967

CLINIC
PO BOX 999
SEATTLE WA 98124

PHYSCIAN MD

SEE LAST PAGE FOR
EXPLANATION OF CODE

PROV#: 999999999900
TAX#: 9999999999
DATE: 05/02/2006
Draft #: 0000000
EDI#: 000000000

PATIENT NAME ACCOUNT #	BENEFIT ID # CLAIM #	APC	SVC DATE	REV/PROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOV'D	CODE	DEDUCTIBLE AMOUNT	COPAY COINS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID
TEST MEMBER	999999999													
C999999	TEST CLAIM-00													
			03/20/06	99213	1	75.00	65.32	.00	PPU	.00	6.53	9.63	6.53	58.79
			03/20/06	36415	1	60.00	43.07	.00	PPU	.00	4.31	16.93	4.31	38.76
	APDRG			**CLAIM TOTAL**		**135.00**	**108.39**	**.00**		**.00**	**10.84**	**26.56**	**10.84**	
													PAYMENT	97.55

TOTAL PAID 97.56

Code Descriptions

****
PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTING TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.
****
PPU THIS IS YOUR PLANS PARTICIPATING PROVIDERS CONTRACTUAL ALLOWANCE FOR THIS SERVICE. PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.
*** REQUESTS FOR RECONSIDERATION OF THE WAY A CLAIM WAS PROCESSED, TO INCLUDE BUNDLING, COB OR ALLOWABLE FEE ISSUES, SHOULD BE DIRECTED TO:
UNIFORM MEDICAL PLAN, P.O. BOX 34578, SEATTLE, WA 98124-1578

200205030003

ENV 3628

F0002166

Appendix A-3

UMP Preferred Drug List

For the most up-to-date version of the *UMP Preferred Drug List* (UMP PDL), please see the UMP Web site at **www.ump.hca.wa.gov**. The UMP PDL is updated quarterly.

UMP Neighborhood
Administered by the Uniform Medical Plan

Appendix A-4

UMP Neighborhood Information

This supplement provides information and instructions for the UMP Neighborhood Care Systems and other providers outside of the Care Systems who may also treat UMP Neighborhood enrollees. Billing and claims submittal procedures for services to UMP Neighborhood enrollees are the same whether or not the provider is affiliated with the enrollee's Care System. However, the enrollee's cost-sharing is higher for most services outside their Care System, with some exceptions.

Section 1

Quick Reference Notes

1.1

How to Reach Us

Find UMP Neighborhood information on the UMP Web site: www.ump.hca.wa.gov

1.1.1 Addresses and Phone Numbers

UMP Neighborhood Customer and Provider Services

- Benefits information
- Claims status and information
- Enrollee eligibility information*
- General billing questions
- Interactive Voice Response (IVR) system
- Medical review
- Notification/preauthorization
- Referral process
- Verify provider's Care System or network status

Automated Enrollee Eligibility Information
Toll-free 1-800-335-1062 (Have subscriber I.D. number available, and select #2 for "PEBB subscriber information.")

UMP Neighborhood
P.O. Box 34850
Seattle, WA 98124-1850

Provider Services
Toll-free 1-800-464-0967
Local..... 425-686-1246
Fax 425-670-3199

Enrollees
Toll-free 1-888-380-2822

Case Management Services
Toll-free 1-888-759-4855

Electronic Claims Submission

The following clearinghouses frequently submit claims electronically to UMP.

Electronic Network Systems
www.enshealth.com
Toll-free 1-800-341-6141

Emdeon Business Services™
(formerly known as WebMD)
www.emdeon.com
Toll-free 1-877-469-3263

MedAvant Healthcare Solutions
(formerly known as ProxyMed)
www.proxymed.com
Toll-free 1-800-586-6870

The SSI Group
www.thessigroup.com
Toll-free 1-800-880-3032

Claims with attachments may also be submitted electronically through Office Ally. You can register for this free service on the OneHealthPort Web site at **www.onehealthport.com**. If you have trouble registering, call Office Ally customer support at 949-464-9129.

Provider Credentialing and Contracting Issues

- Billing manuals and payment policies
- Change of provider status
- Fee schedules
- Network provider applications and contract information
- New provider enrollment
- Policies and procedures
- *Provider Bulletin* feedback

Uniform Medical Plan
P.O. Box 91118
Seattle, WA 98111-9218

Toll-free 1-800-292-8092

Local..... 206-521-2023

Fax 206-521-2001

Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Physicians Network

- Network provider applications and contract information
- Billing procedures
- Fee schedule and payment policy information

American WholeHealth Networks
(Axia Health Management; formerly Alternáre)
Toll-free 1-800-500-0997

Prescription Drugs (retail and mail-order)

- Benefits information
- Claims information
- Cost share information
- Eligibility verification
- Preferred drug list information
- Prior authorization requests
- Network pharmacy information (location and network verification)

Express Scripts, Inc.

Toll-free 1-800-763-5502

To fax prescriptions (providers)

Toll-free 1-800-396-2171

Must be faxed on provider's letterhead (see Section 7.17).

To call in prescriptions (providers)
Toll-free 1-800-763-5502

Preauthorization of prescription drugs
Toll-free 1-800-417-8164

Fax 1-877-697-7192

Appeals and Correspondence
Toll-free 1-800-417-8164
Fax 1-877-852-4070

Express Scripts, Inc.
Attn: Pharmacy Appeals: WA5
Mail Route BLO390
6625 West 78th Street
Bloomington, MN 55439

Vendor for Specialty Prescription Drugs
CuraScript
To call in prescriptions for specialty drugs
Toll-free 1-866-413-4135

Tobacco Cessation Services

Free & Clear

Toll-free 1-800-292-2336

1.1.2 Web Site Information

UMP Neighborhood

www.ump.hca.wa.gov

- *Billing & Administrative* manuals (includes billing and payment policy for UMP Neighborhood)
- *Certificate of Coverage* (benefits book)
- *Network Provider Directory*
- *Preferred Drug List*
- *Professional Provider Fee Schedule*
- *Ambulatory Surgery Center Fee Schedule*
- *Anesthesia Fee Schedule*
- *Chiropractor Fee Schedule*
- *Prosthetic and Orthotic Fee Schedule, Including Ostomy and Urological Supplies*
- All-Patient Diagnostic Related Group Weights used for Hospital Reimbursement
- Other important UMP Neighborhood information

OneHealthPort

www.onehealthport.com

- Register with OneHealthPort for access to secure online services and e-mail to manage your UMP Neighborhood business

U.S. Preventive Services Task Force Guidelines

www.ahcpr.gov/clinic/gspspu.htm

- Preventive care guidelines

Centers for Disease Control's National Immunization Program

www.cdc.gov/nip/publications/ACIP-list.htm

Express Scripts, Inc.

www.express-scripts.com

- General prescription drug information

Note: See the UMP Web site **www.ump.hca.wa.gov** for UMP-specific information on prescription drugs.

Free & Clear

www.freeclear.com

- Tobacco cessation program information

American WholeHealth Networks

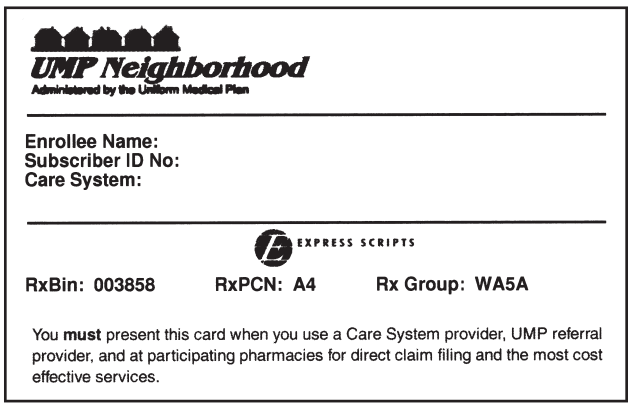
(Axia Health Management; formerly Alternáre)

www.wholehealthpro.com

- Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Physicians—network provider resources information

1.2 Sample UMP Neighborhood Identification Card

This is the identification card that confirms UMP Neighborhood enrollment. **Please note:** The card also identifies the applicable Care System selected by the enrollee. Except as explained in Section 4.1.3 of this appendix, UMP Neighborhood enrollees receive the highest (network) level of reimbursement only when they use providers affiliated with the Care System they have selected.


UMP Neighborhood
Administered by the Uniform Medical Plan

Enrollee Name:
Subscriber ID No:
Care System:

EXPRESS SCRIPTS

RxBin: 003858 RxPCN: A4 Rx Group: WA5A

You **must** present this card when you use a Care System provider, UMP referral provider, and at participating pharmacies for direct claim filing and the most cost effective services.

This card does not guarantee coverage. To confirm eligibility or obtain benefit information and requirements for prior approval, contact the plan at 1-888-380-2822 or 425-670-3018. To find a provider or get benefit information you can also go to www.ump.hca.wa.gov.

FAX UMP NEIGHBORHOOD REFERRALS TO: 425-670-3197

Send medical claims to Electronic Payer ID: 75243
or by mail to: UMP Neighborhood
PO Box 34850
Seattle, WA 98124-1850

Prescription drugs can be purchased at participating retail pharmacies or through our delivery by mail service. For more information, contact Express Scripts at 1-866-576-3862 or www.express-scripts.com.

1.3

Claims Submission Information

Paper claims (CMS-1500) should be mailed within 60 days of service (but not beyond 365 days) to the UMP Neighborhood claims office at the following address:

UMP Neighborhood
P.O. Box 34850
Seattle, WA 98124-1850

Claims with missing, inaccurate, or invalid information will be denied or sent back for clarification and resubmission.

Electronic claims submission provides efficiency to your business.

If you are already connected to one of the following clearinghouses that frequently transmits claims electronically, continue to submit your UMP Neighborhood claims to payer I.D. number 75243.

Electronic Network System
www.enshealth.com
Toll-free 1-800-341-6141

Emdeon Business Services™
(formerly known as WebMD)
www.emdeon.com
Toll-free 1-877-469-3263

MedAvant Healthcare Solutions
(formerly known as ProxyMed)
www.proxymed.com
Toll-free 1-800-586-6870

The SSI Group
www.thessigroup.com
Toll-free 1-800-880-3032

If you are currently submitting paper claims, we encourage you to contact a clearinghouse for information on submitting claims electronically. Providers may also submit claims electronically with attachments to UMP using Office Ally. This Internet-based tool allows providers either to directly enter claims through a Web browser, or upload a batch file from existing claims data systems. Office Ally checks for correct dates, CPT® codes, and ICD-9-CM codes before sending your claims to UMP. You'll receive e-mail confirmation and feedback on incomplete claims within 24 hours. Your practice will be paid faster and the service is ***free***! Examples of attachments UMP can receive include medical reports, X-rays, copy of an enrollee's I.D. card, itemized bills, and other carriers' explanations of benefits. You can register for this free service by clicking on "Office Ally" on the OneHealthPort Web site at **www.onehealthport.com**. Use UMP's payer ID number 75243 when submitting claims,

If you have trouble registering, call Office Ally customer support at 949-464-9129.

1.4

Provider Network Participation

UMP Neighborhood benefits are structured to encourage enrollees to use the services of providers affiliated with the Care System they have selected. As a financial incentive and to promote quality of care, the plan applies considerable cost sharing for enrollees who self-refer to providers who are not in their Care System or on their Care System's panel of referral specialists. There are exceptions for certain provider types (see Section 4.1.3 of this appendix).

Care System providers are expected to refer patients to other providers within their Care System or to specialists who are on their Care System's panel. When it is necessary to refer a UMP Neighborhood patient to a provider who is not affiliated with the patient's Care System, referrals should be to a UMP PPO network provider for services to be reimbursed at the network benefit level. See Section 4.1.3 of this appendix for instructions on notifying our claims administrator of referrals outside the patient's Care System.

The UMP Neighborhood online directory (updated twice a month) is available on the Web site at **www.umpndirectory.net**. You can also view UMP PPO's online provider directory and network pharmacy directory on the UMP Web site at **www.ump.hca.wa.gov**. A provider's participation status can also be confirmed by calling UMP Neighborhood at 1-888-380-2822 or 425-686-1218. For referral to a Uniform Medical Plan PPO provider, call 1-800-464-0967 or 425-686-1246.

1.5

UMP Web Site and Online Services

Refer to Section 1.5 of this manual for information on the UMP Web site and online services that is also applicable to UMP Neighborhood.

1.6

Administrative Simplification Initiatives

Refer to Section 1.6 of this manual for information on administrative simplification initiatives that is also applicable to UMP Neighborhood.

Section 2

Program Outline

2.1

Overview of UMP Neighborhood

UMP Neighborhood, which is administered by the Uniform Medical Plan (UMP), provides coverage to enrollees in King, Snohomish, and Pierce counties. UMP Neighborhood enrollees have the same benefits as those enrolled in UMP's traditional preferred provider organization (PPO), but they receive care from a more limited choice of network providers. As of January 1, 2006, health care services provided to UMP Neighborhood enrollees are no longer subject to a medical/surgical deductible. The annual prescription drug deductible still applies to UMP Neighborhood enrollees. The plan's goals include offering incentives to both providers and enrollees to make cost-effective health care decisions, and providing more affordable plan choices for PEBB members.

UMP Neighborhood is built upon organized "systems of care" consisting of primary care providers, and a panel of specialists and facilities chosen by the Care System. Primary care providers can participate in only one Care System. Specialists and hospitals may participate in multiple Care Systems.

There are currently 12 UMP Neighborhood Care Systems participating. They are identified with their Care System code on the Web site at **www.ump.hca.wa.gov/nhood/** and in the *UMP Neighborhood Provider Directory*. The directory also includes information provided by each of the Care Systems about their program.

Refer to the *UMP Neighborhood Certificate of Coverage* (COC) for deductible (prescription drug), coinsurance, and copayment requirements, as well as for a complete description of plan benefits and scope of coverage. The COC is available on the UMP Web site at **www.ump.hca.wa.gov/nhood/** or by calling 1-888-380-2822.

2.2

Fee Schedule Methodology and Coding Information

Refer to Section 2.2 of the *UMP Billing & Administrative Manual* for fee schedule, coding, and payment information that are also applicable to UMP Neighborhood. **Please note:** UMP Neighborhood uses the Uniform Medical Plan (UMP) fee schedule(s) for reimbursement of claims. The UMP fee schedules are available on the UMP Web site at **www.ump.hca.wa.gov**.

Section 3

Billing Instructions

Refer to Section 3 of this billing manual for instructions on completing the CMS-1500 claim form. Information pertaining to the explanation of benefits (EOB), and detail of remittance (DOR) notices is also available in this section.

Below is an example of how the coordination of benefits process works for UMP Neighborhood. See Appendix A-5 for a sample of the UMP Neighborhood EOB and Appendix A-6 for a sample of the UMP Neighborhood DOR.

3.1

Coordination of Benefits

For other services, here's how it works when UMP Neighborhood is not the primary payer:

- The primary payer pays a portion of the bill and sends the enrollee an Explanation of Benefits (EOB); the enrollee sends a copy of the bill and the EOB to UMP Neighborhood;
- UMP Neighborhood reviews the primary plan benefit calculation, and the primary plan payment;
- UMP Neighborhood determines what the normal benefit would have been if UMP Neighborhood had been the only payer;
- UMP Neighborhood compares allowed charges and determines which is the highest allowed charge; and
- UMP Neighborhood pays the difference between the highest allowed charge and the primary plan's payment, up to the normal UMP Neighborhood benefit amount.

Here's an example to illustrate the process and terms above. This example assumes that the primary plan ordinarily pays 80% of allowed charges after a $500 deductible.

Provider's charge	**$1,200**
Primary Plan Benefit Calculation	
Primary plan's allowed charge:	$1000
Primary plan deductible:	$500
Primary plan pays:	$400 (80% of $500 balance)
UMP Neighborhood Benefit Calculation	
UMP Neighborhood allowed charge:	$900
UMP Neighborhood normal benefit:	$810 (90% of $900)
Actual Payment by UMP Neighborhood	
Highest allowed charge: (primary plan)	$1000
Primary plan's payment:	$400
UMP Neighborhood pays:	**$600**

Section 4

Provider Information

4.1 Provider Requirements

UMP Neighborhood Care System providers agree to comply with the following requirements.

4.1.1 Credentialing Information

- Maintain applicable licensure, registration, and/or certification.
- Maintain professional liability insurance coverage with limits of liability as determined by HCA/UMP.
- Meet all other UMP Neighborhood credentialing requirements.
- Submit provider updates following the UMP Adds/Terms/Changes (ATC) submission process provided in Appendix A-7.
- Accept UMP fee schedules and follow UMP policies and procedures.

4.1.2 Billing Information

Refer to Section 4.1.2 of this manual for billing information that is also applicable to UMP Neighborhood.

4.1.3 Referrals and Authorizations

UMP Neighborhood Care Systems are responsible for managing their panel of providers, including referral specialists. In most cases, UMP Neighborhood enrollees must use the providers in their selected Care System or its panel of referral specialists to obtain the maximum level of benefits. When referring a patient for care outside of their Care System's panel, Care System providers should refer UMP Neighborhood enrollees to a provider within the UMP PPO network unless one is not available for the type of care needed. In addition, the Care System provider should issue a *UMP Neighborhood Pass* when referring the patient outside of his or her Care System's panel. The main purpose of the *UMP Neighborhood Pass* is to notify our claims administrator how to reimburse the claim. With the pass, covered services provided by UMP PPO network providers are paid at the network benefit level (usually 90 percent of allowed charges). Covered services provided by providers not in the UMP PPO network are paid at the out-of-network benefit level (usually 80 percent of allowed charges).

Please note: Care System providers do not need to notify our claims administrator of a referral to the following provider types. Enrollees receive network-level benefits when self-referring to any UMP PPO network provider of the following types. Note below some limits on services when self-referring.

- Acupuncturists
- Alcohol/chemical dependency centers and substance abuse treatment facilities
- Ancillary facilities such as home health or hospice agencies, ambulatory surgery centers, and skilled nursing facilities
- Audiologists
- Behavioral health providers such as psychologists, psychiatrists, licensed mental health counselors, licensed social workers, licensed marriage and family counselors, and psychiatric nurses (ARNP)
- Chiropractors
- Community mental health agencies
- Durable medical equipment suppliers
- Hearing aid fitters and dispensers
- Massage therapists (must be a UMP PPO or American WholeHealth Network massage therapist, and services require a written treatment plan from a qualified clinician)
- Midwives
- Naturopathic physicians
- Optometrists (if outside care system, self-refer only for routine vision services)

- Ophthalmologists (if outside care system, self-refer only for routine vision services)
- Pharmacies/pharmacists
- Prosthetic and orthotic suppliers
- Skilled nursing facilities
- State mental hospitals
- Tobacco cessation program (*Free & Clear* is the only tobacco cessation program covered)

The following hospital/facility-based physicians who may not be included in the patient's Care System but are necessary for the treatment of the patient will be considered as Care System providers if they are in the UMP PPO provider network:

- Anesthesiologists
- Emergency room physicians
- Radiologists
- Hospitalists
- Pathologists

Finally, the following facilities/suppliers are also considered Care System providers if they are in the UMP PPO provider network:

- Free-standing radiology facilities (including physicians interpreting the x-rays)
- Independent lab facilities

Ambulances and free-standing urgent care facilities will be covered at the out-of-network benefit level (usually 80 percent of allowed charges).

A copy of the *UMP Neighborhood Pass* for referrals outside of the enrollee's Care System is included on the following page. The pass is also available online. The Care System should fax the completed pass to UMP Neighborhood at 425-670-3197, or complete it online and e-mail it through our secure Web site. In addition, the Care System should give a copy of the pass to the patient for the provider to whom they are referred.

4.1.3.1 Self-Referral for Women's Health Care

For covered women's health care services, UMP Neighborhood enrollees will receive network-level benefits when they self-refer to a UMP PPO provider (physician, physician assistant, midwife, or advanced registered nurse practitioner)—regardless of whether the provider is affiliated with their Care System. Women's health care services include:

- Maternity care, reproductive health services, and gynecological care;
- General examinations, preventive care, and medically appropriate follow-up visits for the services previously mentioned or other health services particular to women;
- Appropriate care for other health problems that are discovered and treated during a visit for covered women's health care services.

If a woman self-refers to a non-network provider within Washington State for women's health care services, covered services will be reimbursed at the non-network benefit level.

Uniform Medical Plan
Your health. Your plan. Your choice.

UMP Neighborhood Pass

For _____

For Referrals Outside the Care System

Please fax to UMP Neighborhood at 425-670-3197, or complete form online and e-mail through our secure Web site at* www.ump.hca.wa.gov*.

Note: This form does not imply coverage of services not covered by UMP Neighborhood, or those requiring preauthorization. See the *UMP Neighborhood Certificate of Coverage* for details.

***Provider**: Please give the patient a copy of this form.* ***Patient:** Give your copy to the provider to whom you are referred.*

Patient and Subscriber Information

Patient Name _____ Date of Birth _____

Subscriber Name _____ Subscriber ID # _____

Patient Home Phone _____

Provider To Whom Referral is Being Made

Referred To

_____ Provider (Last, First)

_____ Type of Provider (such as M.D. or D.O.)

_____ Street Address

_____ Specialty

_____ City/State/ZIP Code

_____ Phone Number

Reason for Referral and Referring Provider

Diagnosis _____ ICD-9 Code _____ Date of Referral _____

Reason for referral _____

_____

Expected length of treatment _____

Referral requested for Consultation Consultation/Test/Treatment All Services

Referred By

_____ Print Provider Name

_____ Provider Address

_____ Provider Signature

_____ City/State/ZIP Code

_____ Phone Number

_____ Fax Number

Section 5

Enrollee Responsibilities

5.1

Enrollee Requirements

UMP Neighborhood enrollees should seek all medical care through providers within the Care System as identified on their I.D. card, except for providers/facilities that they can self-refer to as previously indicated in Section 4.1.3 of this appendix. If they seek medical care outside of the Care System without a *UMP Neighborhood Pass* when required, payment for covered services will be at the UMP non-network benefit level (generally 60 percent of allowed charges).

Enrollee education is an important factor in ensuring the timely and appropriate payment of health care benefits. When seeking health care, UMP Neighborhood enrollees have the responsibility to:

- Use their UMP Neighborhood Care System and network providers when available to help ensure quality care at the lowest cost.
- Identify themselves as a UMP Neighborhood enrollee when calling for an appointment.
- Present their identification card at the time services are rendered.
- Understand UMP Neighborhood benefits, including what is covered, preauthorization and review requirements, and other information described in the *UMP Neighborhood Certificate of Coverage*.

UMP Neighborhood enrollees may change to a different Care System during the plan year with at least 30 days' notice. If the new Care System is accepting new patients, coverage is effective the first of the month following the 30 days' notice. In these circumstances, UMP Neighborhood will issue a new I.D. card to the patient to reflect the change to a different Care System.

If your patients have questions regarding UMP Neighborhood benefits, network provider status, or payment of their claims, please refer them to:

UMP Neighborhood Customer Service
Toll-free 1-888-380-2822
Local..... 425-686-1218

Section 6

Utilization Review Requirements

Refer to Section 6 of this manual for preauthorization and utilization review requirements, including review criteria and case management information that are also applicable to UMP Neighborhood. Care System providers are encouraged to contact case management on all catastrophic cases.

Section 7

Payment Rules

7.1 General Information

7.1.1 *UMP Neighborhood Certificate of Coverage*

The *UMP Neighborhood Certificate of Coverage* (COC) (available on the UMP Web site at **www.ump.hca.wa.gov** or by calling 1-888-380-2822) is the official source of plan benefits and scope of coverage information. Providers must rely on the COC to obtain full and complete information regarding the scope of coverage and benefit provisions of UMP Neighborhood.

7.1.2 Plan Payment Provisions for Providers

UMP Neighborhood enrollees are not subject to an annual medical/surgical deductible, which means the plan begins paying benefits for covered services with the first health care service. Enrollees are responsible for an annual prescription drug deductible. See the *UMP Neighborhood Certificate of Coverage* for more details.

The plan's payment provisions generally are as follows:

- For covered services from **providers affiliated with the enrollee's Care System, or from providers of the types listed in Section 4.1.3 of this appendix who are contracted with UMP PPO**, the plan pays 90 percent of the allowed charge. (The "allowed charge" is the provider's billed charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 10 percent.
- For covered services from **other providers**, the plan pays:
  - 90 percent of the allowed charge when a *UMP Neighborhood Pass* has been issued **and** the provider is a UMP PPO network provider. (The "allowed charge" is the provider's billed charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 10 percent.
  - 80 percent of the allowed charge when a *UMP Neighborhood Pass* has been issued and the provider is not a UMP PPO network provider. (The "allowed charge" is the provider's billed charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 20 percent plus any difference between the allowed and billed charges.
  - 60 percent of the allowed charge when a *UMP Neighborhood Pass* has not been issued, regardless of whether the provider is a UMP PPO network provider or is participating as a UMP Neighborhood provider with a different Care System. (The "allowed charge" is the provider's billed charge or the fee schedule amount, whichever is less.) In this circumstance, the enrollee is responsible for the remaining 40 percent if the provider is a UMP PPO network provider. A UMP PPO network provider cannot bill the enrollee for any difference between the billed and allowed charges. If the provider is not a UMP PPO network provider, the enrollee is responsible for the remaining 40 percent plus any difference between the allowed and billed charges.

For all providers (Care System, UMP PPO, and non-network), UMP fee schedules and payment policies determine the allowed charges used for UMP Neighborhood reimbursement. These fee schedules and the UMP billing manual are available on the UMP Web site at **www.ump.hca.wa.gov**. Note that a payment differential applies to

certain categories of providers. This differential is described in Section 7.1.3 of this billing manual.

In referral situations where a *UMP Neighborhood Pass* is not required as indicated in Section 4.1.3 of this appendix, UMP Neighborhood payment is based on the network or non-network status of the provider and the applicable benefit.

Emergency care from non-network providers is based on 80% of allowed charges.

For details regarding benefits and scope of coverage for UMP Neighborhood enrollees, see the *UMP Neighborhood Certificate of Coverage*. As explained in that document, UMP Neighborhood enrollees have an annual medical/surgical out-of-pocket limit, as well as some benefit limits. When benefits are paid as network or "out-of-network" (generally used to refer to situations when the enrollee did not have access to network services, as determined by UMP), the enrollee's coinsurance and copayments count towards his/her annual medical/surgical out-of-pocket limit. "Non-network" services (when the enrollee had access to network services but did not use them) are not counted towards the enrollee's medical/surgical out-of-pocket limit. Once the enrollee's medical/surgical out-of-pocket limit is reached, most network and out-of-network services will be paid at 100 percent for the remainder of that calendar year. Specific benefit limits, however, still apply.

Note: Services rendered under private contracts by providers who "opt out" of the Medicare program will not be covered or reimbursed by UMP Neighborhood. Exceptions are services provided on an emergency/urgent basis or that are excluded under the Medicare program, such as routine eye exams and certain preventive care services/procedures, which will be processed and paid according to UMP Neighborhood benefits. In a private contract situation, the enrollee is solely responsible for the provider's total billed charges.

Refer to Sections 7.1.3 through 7.21 of this billing manual for additional payment rules and other information that are also applicable to UMP Neighborhood.

Section 8

Provider Inquiries, Complaints, Reconsideration Procedures, and Dispute Resolutions

Refer to Section 8 of this billing manual for procedures for inquiries, complaints, claims reconsideration requests, and dispute resolutions that are also applicable to UMP Neighborhood.

UMP NEIGHBORHOOD

Explanation of Benefits

01/06/2006

Your UMP Neighborhood ID: W999999999
Subscriber Name: UMPN MEMBER
Patient Name UMPN DEPENDENT
Claim Number: 999999999-00

If you have questions, contact us:

By Mail:
UMP Neighborhood
PO Box 34578
Seattle, WA 98124-1578

By Phone/E-mail:
Local: 425-686-1218
Toll Free: 1-888-380-2822
E-mail: www.ump.hca.wa.gov

UMPN MEMBER
PO BOX 999
SEATTLE WA 98124

Provider Information

PHYSCIAN MD
999 VILLAGE PLAZA
SEATTLE WA 98124

Provider Name:	Date(s) of Service	Service(s) Provided	Amount Charged	UMP Allowed	PPO Savings	Non-Cov'd Amount	Deductible	Copay	Co-Ins. %	UMP Paid	Patient's Responsibility	See Notes Section
PHYSCIAN MD	01/03/06 - 01/03/06	99213 OFFICE/ HOME/ CLINIC VISIT	85.00	70.00	15.00				90	63.00	7.00	
		TOTALS	**85.00**	**70.00**	**15.00**	**0.00**				**63.00**	**7.00**	

Other Insurance Paid Amount	**.00**
(*) See Notes Adjustment	**0.00**
UMP Final Paid Amount/Check	**63.00** # **999999**

Total Payment to Provider: ******63.00 **Total Payment to Enrollee:** *******0.00

NOTES:

THANK YOU FOR USING A UMP NEIGHBORHOOD CARE SYSTEM PROVIDER

GENERAL INFORMATION:

APPEALS PROCESS

If you disagree with any claims decisions on this notice, call the phone numbers listed under "Contact us."
Most problems can be resolved by phone. However, if you cannot resolve the problem at that level, you can request an appeal within 12 months of this notification. Following the instructions below.

1. Circle the items you disagree with and attach an explanation of why you disagree.
2. Send this information to:

   UMP Neighborhood
   First Level Appeals
   PO Box 34578
   Seattle, WA 98124-1578
3. Keep a copy of this Explanation of Benefits for your records.
4. Sign here: _____ Daytime Phone Number: ( ) ____-_____

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L1561020164

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ENV:3628

UMP NEIGHBOR HOOD
P O BOX 34850
SEATTLE WA 98124-1850
Toll Free: 1-800-464-0967

CLINIC
PO BOX 999
SEATTLE WA 98124

PHYSCIAN MD

SEE LAST PAGE FOR
EXPLANATION OF CODE

PROV#: 99999999900
TAX#: 9999999999
DATE: 05/02/2006
Draft #: 0000000
EDI ID#: 000000000

PATIENT NAME ACCOUNT #	BENEFIT ID # CLAIM #	APC	SVC DATE	REV/PROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOV'D	CODE	DEDUCTIBLE AMOUNT	COPAY COINS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID
TEST MEMBER	999999999													
C999999	TEST CLAIM-00													
			03/20/06	99213	1	75.00	65.32	.00	PPU	.00	6.53	9.63	6.53	58.79
			03/20/06	72040	1	60.00	43.07	.00	PPU	.00	4.31	16.93	4.31	38.76
	APDRG			**CLAIM TOTAL**		**135.00**	**108.39**	**.00**		**.00**	**10.84**	**26.56**	**10.84**	
													Pavment	97.55

TOTAL PAID 97.55

Code Descriptions

****

PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTING TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.

****

PPU THIS IS YOUR PLANS PARTICIPATING PROVIDERS CONTRACTUAL ALLOWANCE FOR THIS SERVICE. PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.

******* REQUESTS FOR RECONSIDERATION OF THE WAY A CLAIM WAS PROCESSED, TO INCLUDE BUNDLING, COB OR ALLOWABLE FEE ISSUES, SHOULD BE DIRECTED TO: UNIFORM MEDICAL PLAN, P.O. BOX 34578, SEATTLE, WA 98124-1578

Appendix A-7

Adds/Terms/Changes (ATC) Submission Process

This section applies to both UMP PPO and UMP Neighborhood as described below.

I. Additions

A. **Delegated Providers**

Provide UMP Provider Services a spreadsheet or Provider Profile, in writing or on diskette, that includes the following information. ***Provide updates on a monthly basis:***

1. Name and professional degree
2. Gender
3. Date of birth
4. Specialty
5. Social security number
6. DEA number (if applicable)
7. UPIN or NPI number (if applicable)
8. Washington license or certification number
9. Practice location and phone number
10. Billing address information
11. Copy of W-9 form
12. Accepting new patients (yes or no)
13. Advertise in provider directory (yes or no)
14. Obstetric services (yes or no)
15. Optional: Language(s) other than English; after-hours phone number/pager

B. **Solo and Non-Delegated Providers**

Call Provider Services to request a new provider application packet at 1-800-292-8092. Complete and submit the new provider application/provider profile as instructed.

II. Terminations

Notify Provider Services of termination date of network provider:

Via e-mail to: umpprovider@hca.wa.gov

By mail:

Uniform Medical Plan
P.O. Box 91118
Seattle, WA 98111-9218

By fax: 206-521-2001

III. Changes

Notify Provider Services in writing via e-mail, fax, or mail (as shown earlier) of any change of the network provider status—i.e., provider name; address change; tax I.D. change; formal or informal disciplinary actions; Medicare Sanctions; loss of hospital privileges; loss of malpractice coverage, etc.

Process for Updating Specialist Referral Panels
(applies to UMP Neighborhood Care Systems only)

UMP Provider Services will send a monthly report to each Care System with a list of their designated referral providers. Each care system should update this report with any changes (additions, terminations, etc.) and return it to UMP Provider Services promptly.

Note: Any changes will be noted in the UMP Neighborhood online directory, which is updated twice a month.

Corrected Claim—Standard Cover Sheet

Health Plan: _____ **Product:** _____

Attention: _____

Date Cover Sheet Prepared:

♦ **This is NOT a DUPLICATE claim. Please forward to the appropriate area for reprocessing.** ♦

Be sure to attach the updated claim form!

Claim Identification Information:

Original Claim Number (from voucher): _____

Provider Office Contact Person:

Name: _____ Phone Number: _____

Other Information: _____

This claim is a corrected billing of a previously processed claim for the following reason(s):

- ❑ Corrected diagnosis
- ❑ Corrected procedure code (CPT or CM)
- ❑ Corrected date of service
- ❑ Addition, or correction, of modifier
- ❑ Corrected charges
- ❑ Corrected provider information
- ❑ Corrected patient information
- ❑ Other: _____

Any specific clarification/comment/instructions (e.g., the claim line that was corrected):

Supporting Documentation Attached? ❑ **Yes** ❑ **No**

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